Monday, 18 November 2024

(9.50 am)

LADY JUSTICE THIRLWALL: Ms Brown.

MS BROWN: Yes, we are calling Ms Dodd this morning.

LADY JUSTICE THIRLWALL: Ms Dodd, would you like to come forward?

MS SHARON DODD (affirmed)

Questions by MS BROWN

LADY JUSTICE THIRLWALL: Do sit down.

MS BROWN: If you could please state your name.

A. Sharon Dodd.

Q. You provided a statement to the Inquiry dated 20 June 2024 and is that true to the best of your knowledge and belief?

A. It is.

Q. Turning to your qualifications, you qualified as a Registered General Nurse in November 1979 and as a midwife in May 1981?

A. That is true.

Q. You became a Registered Health Visitor in 1987?

A. I did.

Q. In terms of your career, from 1980 to 1987 you worked as a midwife at the Countess of Chester Hospital?

A. Yes.

Q. You subsequently worked as a health visitor?

A. Yes.

Q. Have you at any point in your nursing career worked on a neonatal ward?

A. Never.

Q. In 2010 you commenced your role as a specialist nurse in what is now the Cheshire and Wirral Partnership NHS Foundation Trust in the safeguarding department?

A. I did.

Q. You stayed in that role until 2019?

A. Yes.

Q. Are you still working within the NHS?

A. Yes. In 2019 I retired and then returned part-time to a slightly different role.

Q. Is that a paediatric liaison role?

A. Yes.

Q. So that is no longer within the safeguarding department and no longer within the CDOP?

A. I am actually based within the safeguarding team but I am paediatric liaison health visitor, yes.

Q. Do you still have any involvement with the Child Death Overview Panel?

A. No.

Q. Turning then to your role in 2015/2016, what safeguarding training did you receive for that role?

A. For the role of?

Q. The role where you were -- we will come to it, but paediatric liaison nurse but also you were working with CDOP, I think one day a week, the Child Death Overview Panel?

A. Okay. As a health visitor you receive -- as in any of my professional roles I have received quite a lot of safeguarding training. But for that particular role I was needing to, required by virtue of the role that I was doing to actually complete Level 1, Level 2 and Level 3 of safeguarding training, which is documented in the intercollegiate document and Working Together to Safeguard Children.

Q. Was Level 3, that was the top of the safeguarding training?

A. Yes, and in actual fact you can actually do Level 4 training, but I didn't at that time.

Q. In terms of how practically that happened, was that in-person training or online training?

A. No, so at that time it was all face to face.

Q. Can you recall when that was delivered and whether -- how often you would have updates of that training?

A. You have to have updates regularly and it was delivered regularly and actually as part of the safeguarding team I used to deliver the Level 3 safeguarding training as well at that time.

Q. When you say "regularly", how often are we speaking about?

A. Level 3 training is -- in that kind of role you would be expected to update every year.

Q. You said you were delivering the training?

A. I would deliver training as well, yes.

Q. Were you receiving training every year as well?

A. Yes.

Q. Who was giving you that training?

A. The -- my colleagues from the safeguarding team but also at that time from what was then called the LSCB, Local Safeguarding Children's Board, we would be expected to attend relevant training delivered by the Local Safeguarding Children's Board as well.

Q. When you are talking about your colleagues, specifically who was --

A. Within the safeguarding training where I worked we delivered the training as part of the safeguarding team.

Q. Who specifically was training you, do you

recall?
A. Do you want names, or?
LADY JUSTICE THIRLWALL: Yes, please.
MS BROWN: Yes.
A. At that time in my team there was Satwinder Lotay, Jill Cooper, Karen Pygott, Steve Lee, there was a whole team of us.
Q. Was there anybody who was working at the Countess of Chester who was giving you safeguarding training?
A. No, nobody at all. We were completely separate. Cheshire and Wirral Partnership Trust deliver their own training, Countess of Chester deliver their own training, so there was no overlap in training.
Q. Within that training, and I am talking then about the training you were receiving but also the training you were giving, do you recall any training making reference to cases such as Beverley Allitt or Harold Shipman?
A. Absolutely. Actually, as part of delivery of training we would include relevant serious case reviews and relevant information that we would impart to people that we were training. But also we would be receiving that training from other areas, certainly the LSCBs to deliver a lot of training around, you know, serious case

reviews that were relevant.
Q. You say "serious case reviews", but very specifically were you trained and referred to the case of Beverley Allitt?
A. Absolutely, yes.
Q. So were you familiar -- maybe not with the number of the recommendation, but were you familiar with the recommendation of the Clothier Inquiry into Beverley Allitt that all those caring for children should be aware of the possibility of malevolent intervention as a cause of unexplained clinical events?
A. Yes.
Q. That was something that you were familiar with as a concept?
A. We were familiar with, yes.
Q. In your Child Death Overview Panel role, you were looking at the full range of causes of death of children: natural, accidental and deliberate harm?
A. Yes.
Q. I think you have probably given the answer but just to confirm was deliberate harm by a healthcare professional something that was alert to you as a possibility?
A. Yes.
Q. Just looking at how your role was divided,

I think your time was split and you worked four days a week as a paediatric liaison role; is that correct?
A. That's correct, yes.
Q. Very briefly, what did that aspect of your role involve?
A. The paediatric development role was developed as a result of the Victoria Climbié Inquiry many years ago and it stated at that time, amongst other things, that district general hospitals should have a paediatric liaison health visitor who would be the conduit between the hospital and the community in order to relay any relevant information around children's attendances. So that was the main thrust of the role that I would be looking at, A&E attendances, Accident & Emergency attendances for children under the age of 18 and giving some level of scrutiny to those attendances. And also within our Trust we also looked at children who potentially might have life threatening illnesses or long-term illnesses that might benefit from additional support within the community and therefore we would be relaying that information as well.
So any child on the children's ward who may have a new diagnosis, say, of a malignancy we would be relaying that information quite quickly to their community practitioner so that they were aware of that

and could support the family more robustly.
Q. When you are talking about liaison there, the hospital you are talking about here is the Countess of Chester?
A. Countess of Chester but also regionally. So, for example, if a child attended an A&E department in, say, Devon, they would send me the information around that child's attendance and likewise if we had a child in the Countess of Chester who lived in Devon, for example, we would send it to them.
Q. Yes. Then turning to the one day a week that you were worked as a Child Death Overview Panel nurse. Did that division then, the four day/one day division, did that remain the same from 2010 to 2019 when you were in that role?
A. More or less. Some -- some weeks you would actually be doing more of one than the other but they did overlap quite nicely because of the -- being a conduit between the hospital and the -- and the community actually was quite -- quite seamless in that respect.
Q. The Child Death Overview Panel was a minority aspect of your role, was it?
A. It could -- it could be, but some weeks you might be doing more of that than paediatric liaison. It

would just depend on what was actually happening at that time, so if there was a Rapid Review Meeting, for example, for a child death then you would prioritise that.

Q. Just so that we can understand the set-up, the Child Death Overview Panel that you sat on was the Pan-Cheshire Child Death Overview Panel?

A. That's correct.

Q. That covered four areas: Cheshire East Cheshire West and Chester, Halton and Warrington?

A. That's correct.

Q. They were the four areas.

That Pan Cheshire Child Death Overview Panel was chaired by Hayley Frame?

A. At that time.

Q. At 2015/2016?

A. Yes, during that time I sat on the panel I think there were three or four independent chairs but at that time, yes, I think Hayley Frame.

Q. At that panel, when the panel sat, each of the four areas would be represented by a specialist nurse and you were the nurse for the Cheshire West and Chester area?

A. That's actually not quite true because not every area had a specialist nurse. So Warrington didn't

always have a specialist nurse but they did have a specialist nurse employed at some point during the time I sat on the panel and Halton didn't have a specialist nurse.

Q. But when you sat you were sitting specifically in relation to Cheshire West and Chester?

A. That's correct.

Q. Also on the panel there were designated doctors from different areas?

A. That's correct.

Q. Dr Mittal was the doctor from the Countess of Chester?

A. That's correct.

Q. As well on the panel there were local authority representatives?

A. Yes.

Q. And also police who sat on that panel?

A. Yes.

Q. One of the police members was Detective Superintendent Wenham?

A. That's correct.

Q. The panel, when they reviewed child deaths, they would meet quarterly; is that approximately right from your recollection?

A. More or less quarterly, yes.

Q. In terms of what the Child Death Overview Panel were doing, they were not determining the cause of death because that was for the Coroner or the doctor who signed the medical certificate?

A. That's correct, that's right.

Q. The Child Death Overview Panel sat and considered a case once all the other processes had happened so after an Inquest or after an investigation and then the Child Death Overview Panel came at the end of that process?

A. That's correct and it could actually be quite some time after the, the -- you know the child had sadly passed away, it wasn't always very quick.

Q. Just looking at the specific role that the Child Death Overview Panel was doing. That was set out in the Working Together policy and I think you refer to this in paragraph 9 of your statement.

A. Yes.

Q. But what the Working Together policy says is part of the role of the CDOP, the Child Death Overview Panel, was doing was to learn lessons to prevent further deaths and to identify any wider public health or safety concerns arising from a death or from a pattern of deaths?

A. That's correct.

Q. I think in your statement, you helpfully paraphrase it and you say it involves establishing and you refer particularly to any emerging patterns of death?

A. That's correct.

Q. Now in addition to sitting on the panel when that sat approximately quarterly with the other representatives we have spoken about including the local authority and the police, you say in paragraph 11 your role was to disseminate learning and provide training depending on what was identified in the panel.

Who were you disseminating that learning to, who fell within your remit of people you were giving training to?

A. Because I was employed by Cheshire and Wirral Partnership Trust my -- my learning would be very definitely disbursed within Cheshire and Wirral Partnership Trust. However, because we were a Pan Cheshire panel, we would have wider training days and we would actually have conferences where anybody could attend who worked in that locality and, you know, multi-agency, multi professionals and we did actually have a few conferences where it was open for people to attend. It didn't matter what your role was but you could attend those panel -- those training events.

Q. So obviously we are concerned particularly with staff at the Countess of Chester. Would they be people that you would be disseminating your learning to or be attending those conferences --

A. I wouldn't specifically disseminate learning to the Countess of Chester but I would support Dr Mittal. If he wanted to do some training sessions then I would support him. But he would be responsible for disseminating learning in the Countess of Chester.

Q. Can you just give an indication of one or two of the sort of training or learning you are talking about here so we are talking in actual real events?

A. Some -- some of the training packages were about completing forms accurately and well so that the panel could actually review the case robustly really because there was there were in the beginning people didn't really fill in forms terribly well. So there was definitely learning needing to be disseminated around that so that we could actually review the deaths better. Because sometimes in the early days we didn't have electronic forms so people would have a paper copy and maybe just tick a box, there would be no sort of real dialogue in there.

So some of the training involved completing forms, the relevance of completing forms and the purpose of

completing the forms, really, which I don't really think in the early days of CDOP panels people properly understood because --

Q. Sorry --

A. Go on.

Q. You mentioned speaking to Dr Mittal?

A. Yes.

Q. Can you recall any of the training that you did in conjunction with him?

A. He would be part of all of the training packages, particularly the ones where we did a whole day of training and we one of them specifically we did around bereavement as well, he was involved with that. He was involved with disseminating the information about the Form Bs. I do recall him spending an hour or so in the A&E department one morning at the handover for the doctors to actually discuss the actual whole child death protocol with them so that they fully understood it.

I don't know what he did specifically in the Countess but I also did some training with him around the neonatal unit much later around --

Q. When you say "much later", when are we talking --

A. Probably about the end of 2017, I can't remember the date specifically -- I could probably go

back and look but I can't remember the specific dates without looking -- around the use of the SUDiC protocol because it had been identified by the CDOP panel that the SUDiC protocol was not always used correctly in hospitals.

Q. We will come to the SUDiC in a moment. But that -- you recall there being training that you and Dr Mittal did to improve that?

A. We did.

Q. At paragraph 12 you talk about the administrative aspects of your role as a Child Death Overview Panel nurse?

A. Mm-hm.

Q. And focusing specifically on deaths on the neonatal ward at the Countess of Chester. I just want to go through the stages of how the notification and the forms operated.

Now, in very broad overview, and correct me if I get this wrong, Form A was the form that set out the details that the death occurred, that was the initial notification form?

A. Form A was the initial notification form and it was actually quite brief.

Q. Following Form A, Form B was then the form that would be filled out about the relevant

circumstances of the death and in the case of a neonatal death that would be predominantly by midwifes, obstetricians and the neonatal doctors?

A. Yes. The Form Bs from my perspective would be completed by health professionals. The Form Bs would also be completed by other relevant professionals, so they might also be completed by the police, they might also be completed by social care or education but my role was specifically around the Form Bs being completed by health professionals.

Q. Then the form C was what was filled in after the panel had considered the case?

A. That's right.

Q. I am just going to ask some questions as to how that operated in practice and to understand that process I think it's important and if you can confirm that the Child Death Overview Panel who would consider a case that was dependent on where the family lived, not where death occurred?

A. That's correct.

Q. Wales had a similar system but that was referred to as the Child Death Review. You may not be familiar with that?

A. Sorry, say that again?

Q. Wales had a similar system where Child Death

Overview Panels, it was the Child Death Review?
A. Yes, I think Wales was actually called PRUDIC.
Q. I think that was for sudden death?
A. Yes.
Q. But in terms of the CDOP equivalent?
A. I -- I can't comment on that because I never had anything to do with --
LADY JUSTICE THIRLWALL: There is no need for you to --
A. -- the process in Wales.
LADY JUSTICE THIRLWALL: -- do that.
MS BROWN: We are going to go through now, Ms Dodd, the notifications that you received in this case and if I could just remind you not to refer to the actual areas that parents lived in, so we will use the terminology of parents living within the catchment area of the Pan Cheshire panel or outside the catchment area.
A. (Nods)
Q. So regarding first Form A. How would that in fact how would that information receive you, would it be emailed or --
A. At that time --
Q. -- sent to you?
A. -- it wasn't always by email. We had a lot of paper, unfortunately, still in 2015/2016. Now it would

all be electronic. But at that point it could be paper. But it might actually be a phone call. So sometimes if a child had died, for example in Alder Hey, they may ring me and say this is -- this child has sadly died and I would fill in a handwritten Form A but they would then forward theirs.
Q. We will come to that in moment but I think that is what happened in fact in relation to Baby A?
A. It is indeed, yes.
Q. Would all deaths, all neonatal deaths that occurred at the Countess of Chester, always be referred to you in the first instance; regardless of where that child lived, would they always come to you in the first instance?
A. They might not come to any -- in the first instance they might have gone to Dr Mittal. He was the designated doctor for safeguarding and child death so he may have received the information before me. I would be the conduit to inform community practitioners, the LSCB and the designated nurses and my senior managers.
Q. So as the conduit, even if it was Dr Mittal who was informed first you were -- you were the central funnel; it would always come via you?
A. I would get those Form As, yes.
Q. So if there was a death in the neonatal unit,

you would be informed of it?
A. The Form As would come to me yes, that's correct.
Q. So going through now the specific babies that were on the indictment and that this Inquiry are concerned with, and this is paragraph 29 of your statement, it may be helpful if you have that in front of you?
A. Mm-hm.
Q. Baby A we see as you have just alluded to, that in that case you were notified of the death by a nurse and you in fact completed the form?
A. That's correct. She then did send it to me afterwards.
Q. Then you subsequently received a completed Form B and then that was sent on to the Pan Cheshire Child Death Overview Panel because Baby A did live in catchment?
A. That's correct.
Q. I think it would be helpful if we just look at these forms so we can see actually how this was operating. So if I could turn to INQ00001942.
My Lady, this is tab 7 at your bundle?
LADY JUSTICE THIRLWALL: Thank you.
MS BROWN: So we are going to have on the form here

in a moment what is Form B in relation to Child A. And we can see there at the top we have got Child A, in fact when that's been added as a redaction for the purposes of this Inquiry, but there would have been a number there so it was anonymised?
A. There would have been a number because when you reviewed the deaths at panel they were completely anonymous so nobody had an idea who that child was or where they were from.
Q. And working down that form, and this of course is the Form B that was subsequently sent to the Child Death Overview Panel we know on 4 August, we see where was the child at the time of the event in the middle of the form and that's marked as the neonatal unit, and then we see further down the circumstances of the death, and we see that the midwifery did fill in a section some of that's been removed because of sensitivities.
Then HV, so that is the health visitor, and if we turn over the page, we can see no additional information is available, health visitor didn't have an involvement sadly with the baby had died in the hospital.
Then the GP, again not aware of any immediate circumstances leading to the death but sets out some of the maternal history and then really the substance of the form is filled out by the hospital as one would

expect with the neonatal death and they set out the circumstances and then there is a summary of the hospital report?

A. (Nods)

Q. Ensuring that that information was complete, that in a sense was a key part of your role, was it?

A. I would send out, as it's documented in Working Together that the designated person would actually send out those Form Bs and will identify who they should go to from the CDOP panel so the CDOP administrator would often send them out they would come back to me to make sure they were all completed and then the whole package would be then sent to CDOP.

So we would resend the Form A and the Form B to ensure that the CDOP administrator actually had all the information that we could possibly give her.

I didn't analyse the forms because they are not my information, so I would ensure that the people that had been sent them had returned them and if they didn't return them in a timely manner, we would chase them up.

Q. Then you would send it either on to the Child Death Overview Panel of the Pan Cheshire, if that was a within catchment baby, or to the relevant area if it was a without catchment?

A. That's correct.

Q. The form goes on to list -- we don't need to go to all the pages but it goes on to list details, for example family details such as siblings, the service provision, so whether for example the police had been involved, whether in certain cases a hospice would be involved and then maybe we could look at page 6, because you have referred to the bereavement services.

We can see there is a section on bereavement services and that would be filled in and also to consider whether that was a positive or a negative experience so that was another section of the form?

A. That's right.

Q. Yes, that can go down now, thank you.

We have seen and if we can turn to an email, this is INQ 0103110. I'm not sure if we have that on the system. We do.

So this is an email, Ms Dodd, you have been shown this but you weren't copied into this email?

A. No.

Q. But I am taking you to it just because it does refer to you and it's an email exchange between Dr Mittal and Dr Gibbs with some other people copied in and it's discussing the filling out of the Form B and the essence of the email is that Dr Gibbs is saying we have all this information elsewhere, we have already

filled it in on other forms, can we simply forward that information to you as CDOP rather than filling in yet another form and I think we see from Mr Mittal that he had spoken to you and we have agreed we will not ask the paediatrician to complete Form Bs for cases where a postmortem has been requested, we will instead use the information from the dictated letter?

A. That's right.

Q. That was a practice you adopted?

A. Occasionally, yes, because the -- we would find that that information as Dr Gibbs had identified was duplicated. It's a lot of work for the paediatricians -- well, for anybody to complete the Form Bs, they really do need to be robust.

So actually if they were completing a referral for a postmortem or for a discharge letter, for example, which may go even to the parents, there would be a lot, a lot of information in those referrals or letters and we would -- we did discuss that at CDOP panel and actually agreed that some of those letters actually had a lot more information in them than what some paediatricians would put in the Form Bs.

So we agreed that they could be used in those circumstances and so what would then happen is they quite often used to go straight to CDOP, actually, very

often they didn't come to me, and they would be considered at panel, when we reviewed that child, all together.

Q. We can take that down now, thank you.

At this point, so just the dates, so this was the end of September 2015 --

A. (Nods).

Q. -- that Dr Mittal is recording the fact that he had discussed with you about these forms. What was your relationship with -- your working relationship with Dr Mittal? How often would you be communicating with him?

A. I -- I would say that my working relationship with Dr Mittal was good. He would let me know if -- if things were going on. He would let me know of child deaths if he knew before I did, vice versa.

I used to see him at all of the CDOP panels. I didn't see him on day-to-day basis by any means, I might see him once or twice a month maybe but yes, I would say that we did have a good working relationship.

Q. On this occasion, so in about September he's been discussing with you forms. Did Dr Mittal then in September -- we know now that by that stage there had been four neonatal deaths within a very short period,

within a two-month period, in fact three of those deaths within an even shorter period.

Did Dr Mittal discuss that with you, discuss concerns about the increased mortality or concerns about the number of deaths on the neonatal ward?

A. He didn't discuss any concerns as -- as I recall.

We may have discussed that there were three or four neonatal deaths but we didn't discuss that there were any concerns around those deaths and certainly the information that I received didn't alert me to any concerns around those deaths and I do think he would have said so at the time. I do -- I would have expected him to and I would -- I would have thought he would have done.

Q. If we can go back, then, to page 6 of your statement, going through the receipt of forms. So we have looked at Baby A's Form B and Baby A was communicated to you by phone and Form A completed and in due course Form B.

Baby C, the Form A was completed and sent to you but that baby was out of catchment area, so those forms were sent to a different panel?

A. Yes.

Q. And Baby D likewise didn't -- you were

informed but that was a baby that was out of area, out of catchment, so that wasn't dealt with by your CDOP panel?

A. No.

Q. Baby E, again you were informed the combined forms were sent and you forwarded those on accordingly?

A. Mm-hm.

Q. Baby I, like Baby A was a within catchment baby, so Form A you say was completed, Form Bs were completed and they were sent to the panel on 26 November?

A. Mm-hm.

Q. Then Baby O and Baby P, were you informed, were you the conduit for those?

A. No, I wasn't. I -- I don't know why I didn't, I wasn't informed about those. It may have been that I was on annual leave or it may have been that I was doing something completely different and my senior named nurse Jill Cooper dealt with those. I didn't have anything to do with them.

Q. So you personally didn't deal with those?

A. No.

Q. But they went through the same conduit?

A. They will have gone through the same system, yes, because my colleagues would have covered my role if

I wasn't there and indeed anybody within our safeguarding team could have done that.

Q. If we can go then to paragraph 20 of your statement. You say there and I am just going to read that out:

"I kept a log of all forms received for the purpose of my role with CDOP whilst at CWP [Cheshire and Wirral Partnership] and as a result I became aware of 19 neonatal deaths between June 2015 and June 2016. Of those neonatal deaths, I was informed that 13 neonates died at the Countess of Chester Hospital neonatal unit."

We have seen on the form that would be something that would be shown the place of death. Two died at the Countess of Chester labour ward, two neonates died at Arrowe Park neonatal unit, one neonate died at Liverpool Women's Hospital NNU and one died at Claire House Hospice in Wirral.

So you were keeping a log?

A. (Nods)

Q. And that's a significant number of deaths, 13, and perhaps particularly significant set against the fact that just two neonatal deaths in Arrowe Park and one neonatal death in Liverpool Women's Hospital.

You had been in the role since 2010. Had you ever seen that number of neonatal deaths coming from one unit

before?

A. No, there was definitely an increase and we actually did discuss that. We -- we as a safeguarding team we were responsible for providing an annual report and we actually did note it in the annual report as well and we made sure that the LSCB and the designated nurses were aware of that but unfortunately none of the --

Q. Just going back to that, so we can just take it in stages.

When did you discuss it, when were you discussing the concern?

A. I think we have got the date in here actually that we discussed it with the Commissioners.

Q. Well, we discuss it much later, we will come to a meeting in March --

A. Yes, several months later --

Q. That was the one you are referring to the documents?

A. Yes.

Q. But not earlier than that?

A. Not that early on. I mean, I think the timescale was quite broad and certainly as well it spanned over two financial years which potentially may have made us not look at it quite as robustly as maybe we could have done at that time.

Q. What was the significance of a financial year when you had 13 deaths?

A. Because we will have kept our spreadsheets for in a financial year sort of format, if that makes sense.

Q. Well --

A. So we will have gone from 1 April until 31 March one year and then the 1 April until 31 March the next year and so CDOP would certainly count those if all of those baby deaths had been reviewed at CDOP they would all have been counted.

Q. Just -- just pausing there for a moment. So we have understood that they weren't all reviewed by the same panel because of the catchment area issue. But as far as you were aware, you had a list of 13 neonatal deaths?

A. Yes, we did.

Q. We have gone through the fact that the Child Death Overview Panel was there, one of its purposes was to spot a pattern. This was a pattern, wasn't it?

A. It -- it without question yes, and certainly with the benefit of hindsight you can look back and say yes, this was very alarming.

At the time there was nothing to indicate to us that there was a concern and certainly nobody ever said to me that there was anything to be worried about on the

neonatal unit. Nobody ever mentioned that until much, much later on.

Q. Well, just looking at that a moment. The Child Death Overview Panel, because it was there to look at patterns, and because you have identified you as the conduit were the person who could identify that pattern you have identified it?

A. (Nods)

Q. Why were you not then referring that on in June 2016 or at some point before that once you started to become aware of a pattern as it built four then five deaths, and so on? Why were you not referring that, at that point, to the Child Death Overview Panel or to someone?

A. That's a very good question and I can't -- I can't say why we didn't do that at the time. I do know that part of the issue was that they didn't all live in our local area and therefore maybe we didn't see quite as robust a pattern as we potentially could have done.

I think it's very difficult to answer that question for what we did at that time. I think now we would definitely act differently, I think every child death now would be referred to our CDOP panel. At the time that wasn't the process and I don't know why potentially

it wasn't.

We did discuss the child deaths with Paula Wedd, who was one of the senior Commissioners, with Dr Mittal because she was questioning as well why we hadn't picked up something and actually we said --

LADY JUSTICE THIRLWALL: When was that?

A. I --we have got the date here.

LADY JUSTICE THIRLWALL: You are being asked at the moment about --

A. Yes, I know but 16 March 2017, it was.

LADY JUSTICE THIRLWALL: So that is quite a bit later.

A. Yes.

LADY JUSTICE THIRLWALL: But I think what you are being asked about is you kept a log of all the forms and you became aware of those 19 deaths?

A. That's correct, yes.

LADY JUSTICE THIRLWALL: I think that is the timescale I was asking you about, so if you can help us about that?

A. I -- we didn't have any indication that there was anything to be concerned about. The information that we had was that the babies were -- many of them pre-term, many of them unwell, many of them unfortunately quite sick. We didn't have any indication

that --

MS BROWN: Just pausing there a moment, Ms Dodd. You just explained that the Form Bs that came in with the details, that that was that something that you considered or was that something that you sent on for consideration?

A. We sent them on for consideration. It wasn't my role to analyse the Form Bs.

Q. You have been referring to "we" as being aware?

You were the conduit and they came to you?

A. Mm-hm.

Q. Who else was aware of this log that you were keeping? Who else would have been aware of that log?

A. My managers, the designated nurse for safeguarding.

Q. Can you give names where possible?

A. Anne Eccles was at that time the designated nurse for safeguarding. She would have been aware of every single death, the LSCB would have been aware of every single death. Sian Jones, we used to copy her into every -- every single death.

Q. Would Hayley Frame as the Chair of the CDOP panel, would she have been aware of what was on your log?

A. No, she wouldn't have been, because that was -- the reason I kept -- we kept a spreadsheet log was purely to -- well, to understand who we were dealing with but also to manage the Form Bs so that we actually had a timeframe for the Form Bs to come back to us. So if they hadn't come back we would actually have a sort of a way of managing those because otherwise there is no way that you could possibly keep track of all the requests that you had ever made for all of the Form Bs.

So we used to manage that -- we used to manage that spreadsheet purely so that we knew if we had a Form A we now if there was going to be a serious -- a Rapid Review Meeting, we knew who may have been invited, we knew who we had sent the Form Bs to and when we expected them back so that we could follow them up.

Q. Did you, once you had observed this as you have accepted I think pattern and the list -- the growing list of numbers, did you -- was that something you debated with Dr Mittal at any point?

A. We did discuss can with Dr Mittal, yes, and it was --

Q. In March 2017, but we are talking about in 2016?

A. I don't recall discussing a cluster of deaths with him. I don't -- I may -- I think we may have said

oh, not another neonatal death or something like that. But we never ever had the information that there was any concerns. So all of the Form As that we received didn't alert us to any concerns.

Q. They alerted you [to] a pattern but you say not to a concern.

A. Yes, and I think at the time because they didn't alert us to concerns, they didn't alert us to a pattern, if you see what I mean.

Q. Well --

A. I know that there was a number of deaths but we didn't see an emerging sort of pattern of deaths.

Q. Can we go forward then to September 2016 when you are interviewed by the RCPCH and this is INQ0014605 and that's tab 9, my Lady, in your bundle.

So what's going to come up on screen here are the notes that were made by Sue Eardley of the RCPCH and this was an interview she had with you on 2 September 2016 and we can see your name -- sorry have we got the right -- sorry, it's page 19 of that document.

We can see your name "Sharon" and your role "Paediatric Liaison CDOP Pan-Cheshire". Then I think the interview it seems starts with discussing your liaison role and in fact towards the end we see with the

exclamation marks:

"Brilliant role ... Sharon has developed the role. Really good system, health visitors will call Sharon about any worries."

That is what you started off your evidence with explaining the liaison role you did with the hospital and the community in terms of any concerns relating to children.

Then if we could go over the page it seems then the interview turns to look more in relation to your CDOP, the Child Death Overview Panel, role and it says there four lines down:

"Although nurse for CDOP, not good system for child death."

You then go on to talk about bereavement support.

Can you recall what you were referring to there when you are saying "not a good system for child death"?

A. This, this meeting was really brief, really brief and what they were asking me about specifically was my paediatric liaison role and I actually informed them about the CDOP role. They didn't ask me about it, I informed them. And so they basically were just asking me what the -- what sort of -- what I did about it.

Q. And what do you think, when you say "not a good system" do you think you said that and if you

did, what did you think was not a good system at the panel?

A. Not a good system for child death. I don't know what that, I really -- I don't know why they have said that, I --

Q. Did you at the time have reservations at all about the CDOP system?

A. I don't know what that really refers to, to be honest:

"Although nurse for CDOP, not good system for child death. She doesn't do it but gets school nurse and health visitor to do that."

I honestly don't know what that means.

Q. Did you though at the time have concerns about the CDOP system that you might have been referring to?

A. No, I don't think so. I -- I don't know what that -- I honestly can tell you now I don't know what that refers to. I don't know what it means. It is very sort of -- it doesn't have any context to it, does it?

Q. You go on to talk about bereavement. Just very briefly, what was your view of the bereavement services at the time in relation specifically to parents who had a child who died on the neonatal ward?

A. I personally don't think that the bereavement services at that time were very good and we really,

really tried within the CDOP process to improve bereavement services and we developed partnerships with some other agencies, particularly Alder Hey. We just didn't have --

Q. When was that, when were these partnerships being developed?

A. Was it what, sorry?

Q. What timing are we talking about? You said you developed partnerships, when was that?

A. It was throughout the time that I was on the CDOP panel really and we actually did have -- we did go to Alder Hey to one of their bereavement panel -- one of their bereavement training sessions so that we could try and replicate it.

We just we don't have specific bereavement services and we rely on charitable or other organisations to do that. Our community teams will visit families and offer support and we -- you know, if we have a child that dies in a -- you know an educational age, then I know that the Sky team will now provide help and support and signposting for schools, but at that time the bereavement services in my view at that time were not as good as they potentially could have been.

LADY JUSTICE THIRLWALL: Do you think that might be what that note is about?

A. I don't know, maybe that potentially is, yes. It doesn't make sense to me that sentence and I never got the minutes for this meeting and only saw -- I only saw the completed report months afterwards. And I literally was in and out of that meeting honestly in about five minutes.

MS BROWN: Because you go on to talk about bereavement so it's possible, is it, that what you felt was not a good system was related to the bereavement or maybe you can't assist.

A. Possibly, yes.

Q. And if we go on then at the bottom of that page you talk about the Form A and B explain Form A arriving quickly and then information on Form B is robust.

Then there is an entry "across Cheshire", an upward arrow, so increase in number of deaths April 15 to 16.

A. Mm-hm.

Q. Then if we could go over the page:

"Neonates seem to have had higher than average but none congenital abnormalities."

This is you informing the RCPCH?

A. Yes.

Q. What did you understand the RCPCH review was doing?

A. I thought that I knew that the hospital had had an internal Inquiry because CDOP had been informed about that.

Q. What was that Inquiry?

A. Around the cluster of deaths and my understanding was that the review was on the back of that.

Q. So you are being interviewed about the cluster of deaths and you are saying --

A. I was being interviewed.

Q. Higher than average?

A. I was being interviewed at that time about the paediatric liaison role. That is what they asked me to attend for. They didn't ask me to attend in my CDOP role but I told them about it.

Q. And looking then just further down that note, having spoken about the higher than average neonatal deaths, you say they could speak to Hayley Frame, so you are referring them to speak to her if they wish?

A. Yes, because I think they -- I think I indicated to them that -- that the deaths wouldn't have been reviewed at panel at the time. So that the panel may have had the Form A and Form Bs but the deaths may not have been reviewed at panel and therefore that may be why I suggested to her that she spoke to

Hayley Frame.

Q. We see then down the note:

"CDOP not worried nor is Sharon."

Do you think, looking back now, you should have been worried at that point by the number of neonatal deaths?

A. I don't think I would ever have said that, that I wasn't worried, I -- I really don't think I would have said those words and I don't know why that's been documented. I -- I -- I never -- I had never saw the minutes for this meeting until I had them for the Inquiry.

Q. Did the meeting and fact that the RCPCH were looking at a cluster of deaths and you are being interviewed and you end up discussing CDOP, did that not act as an alert to you that maybe this is something that CDOP should be looking at because there was a pattern here and it was worrying?

A. Absolutely and it did get discussed at CDOP.

Q. But not until March and this was September?

A. I can't -- I honestly can't remember the dates that we did discuss things at CDOP without -- without looking at the actual CDOP minutes specifically but potentially not. But, again, even this, even the Royal College review didn't -- nobody ever said to me:

we are very worried about these deaths, would you not be worried about them? Nobody ever said anything about being concerned about events on the neonatal unit.

Q. Then going down on that as well, it seems then there was a discussion about unexplained, we see are:

"Any CDOP neonatal deaths unexplained?"

Then there is reference to the Pan Cheshire SUDiC protocol. There is a comment:

"Will look back and see what were UE [it is not clear whether that is unexpected or unexplained] from Form As."

Is that a reference to you going back to see if some of those deaths were unexplained or unexpected?

A. I would imagine that must be what it meant. But it's just -- there's no context to the -- to the minutes, are there?

I -- I assume these are the -- the only minutes that they have got.

Q. These are just the notes from --

A. Yes.

Q. -- Sue Eardley.

A. Because at the time, I didn't see them, I wasn't given them and only saw them when you sent them to me.

LADY JUSTICE THIRLWALL: Honestly, we do understand

that point.

A. Yes.

LADY JUSTICE THIRLWALL: I think they were in manuscript as well then have been typed up.

A. So it's very difficult looking at this now to say what these minutes actually completely meant. We can make assumptions, but I don't think we can --

LADY JUSTICE THIRLWALL: But I think you probably did say you would go back and see what were --

A. I potentially did.

LADY JUSTICE THIRLWALL: That looks likely, yes.

A. And I probably did, actually, I probably would have done because that's sort of person that I am, I would go and check something, I would robustly look at something.

MS BROWN: Do you think you would have reported back to the panel about this interview and the concerns that now are not only on your log but we are now -- you are now also aware that the RCPCH are carrying out a review in the hospital of the cluster of deaths?

A. I potentially might have spoken to Dr Mittal about it and actually said to him, you know, is there anything we should be concerned about? Is there anything going on?

He never ever indicated to me that there was and he

never ever indicated at panel meetings either that there was.

Q. If we can just go to then see what the actual report said?

A. Yes.

Q. So if we could go to INQ 0009618 at page 21, so this is an extract --

A. Of the actual report, yes.

Q. -- from the RCPCH review, the October 2016 final copy confidential version. We see that they address -- it will come up in a moment -- the child death process.

It says there in relation to unexpected -- under the heading "Child Death Process":

"Where an unexpected paediatric death occurs the paediatrician contacts the senior investigating officer for neonates. The designated doctor is notified. He is responsible for advising Pan Cheshire Child Death Overview Panel."

So that's Dr Mittal --

A. Yes.

Q. -- advising the Child Death Overview Panel whether the deaths are expected or unexpected.

Was that operating in practice?

A. It should do, yes.

Q. Did it in fact operate in practice as far as you were aware?

A. I don't ever recall him having any concerns and saying anything. In actual fact, I don't know whether Dr Mittal was directly informed by the paediatricians of every unexpected death. I can't answer for him.

That is the process and that is what should have happened or should happen. I don't know whether in reality it did because unfortunately these -- you know, the neonatal deaths occurred in the Countess. Dr Mittal worked in the Countess, I didn't.

Q. Then if we can go down, we see at 4.4.25:

"The RCPCH Review Team was concerned that CDOP did not appear to be alert to the cluster of neonatal deaths and for at least some there should have been a Rapid Response Meeting for notification."

Then:

"In their recommendation CDOP should consider whether its processes could have detected the cluster of deaths and initiated external review more swiftly."

Now, Ms Dodd, you were aware of the cluster of neonatal deaths. Do you think -- do you accept that that an external review should have been initiated more swiftly as a result of that knowledge of the cluster?

A. Absolutely. Looking back now, absolutely.
Q. There is also mention there in that report of the unexpected notification Rapid Response Meeting where there was an unexpected death. Turning to SUDiC, were you familiar with the SUDiC protocol?
A. Yes.
Q. What was your understanding as to whether the SUDiC process applied to the death of a neonatal baby born in hospital? Who died unexpectedly?
A. Well, it would apply.
Q. You were clear about that and throughout the period of 2015 to 2016 as far as you are aware there was an unexpected death in hospital, the SUDiC process should have been initiated?
A. Absolutely. The SUDiC protocol at that time was documented by the then LSCB. It was clear. It was quite a lengthy document and I understand that, you know, if you were on any kind of department or A&E it might -- you might need to spend some time looking through it. However, the actual process was clear. There was a flowchart which people could easily follow.
Q. If we can look now to a meeting that happened then on 16 September, so this was a panel meeting that happened shortly after your interview with the RCPCH, so at this stage you are aware of the number of deaths on

the neonatal unit, you are aware that the RCPCH are conducting a review and you have had this discussion with them?
A. (Nods)
Q. Now, that's INQ00178115.
Now, in fact, Ms Dodd, this was -- we will see the attendance log -- a meeting that in fact you didn't attend, you were absent for this meeting. But I just want to look, so we see your name there a few lines down and we can see that you were absent at that meeting, if one works along.
But this was chaired by Hayley Frame, we can see the other attendees where there is an R next to a name so for example Nigel Wenham is there with an "R". Does that mean they attended remotely or does R mean something else?
A. No, we wouldn't have anybody attending remotely there. He might have been a representative for somebody else.
Q. R means they --
A. He may have been representing Serena Kennedy.
Q. So "R" means you were there but you were representing someone else?
A. I think some of the minutes do actually document what those abbreviations stand for.

Q. Yes. Designated rep, you are quite right.
On the following page, if we can go then to page 2 just to see what was discussed, because at that under review of children's cases, the second action point there is that you closed a case there and that's relations to Child I?
A. Mm-hm.
Q. And it says the child case referred to once the College report is presented by Dr Mittal?
A. (Nods)
Q. Was it unusual that a case was being closed when the RCPCH report hadn't been received?
A. No, it would -- normally we wouldn't close cases until absolutely everything was received.
Q. Right.
A. And actually what we would do if we didn't think we had everything, we would refer back and get that information.
Q. You weren't at this meeting?
A. No.
Q. So we have to ask other people about that.
But it also then says action item to be added to the November meeting, subsequent meeting to consider that unexpected deaths in hospitals should be referred for RR meeting, so Rapid Response Meetings?

A. Mm-hm.
Q. Do you think that action came up because the RCPCH had been asking you about whether -- whether the SUDiC system had been followed, whether there were Rapid Response or SUDiC protocols being followed, do you think you referred that to the panel?
A. It -- it may have been that or it may have been that Dr Mittal actually highlighted that -- the same sort of issue. I can't -- can't comment on which one it was, but I would assume it was either of those, yes.
Q. If we can then go to a panel meeting that you were at and this is the one you have referred to a number of times, the one in March, so that's INQ0012008. So just to situate that in the timeframe, this clearly is quite a few months after the RCPCH have interviewed you?
A. (Nods)
Q. We see in terms of attendees we have got Hayley Frame who's chairing it, you are attending, we have -- I can't see now but, yes, Dr Mittal, and Nigel Wenham who are all at this meeting and if we can then turn to page 3.
We see there that at this point, in March, it does seem that there is a concern about the trends. It says:

"The meeting discussed in depth the death, the geographical area the children lived and the CDOP processes and what could be done within the CDOP process to ensure that trends can be or should be identified by the Pan Cheshire panel."

So I think it's at this meeting, is it, that they are recognising that the trends hadn't been picked up?

A. Yes.

Q. They make the point that the panel itself wouldn't have been seized of this but as we have discussed, there was an awareness of the number but the panel would only have been discussing the deaths within their areas.

It said going down:

"... Gill Frame asked can the CDOP be improved, suggested this Form A could be amended, a place of residence as well as a place of death would be collated."

But in fact all the Form A material was already being collated by you, wasn't it, so although it was being pushed out to other areas, the Form A material --

A. We did have a log of them, yes.

Q. It goes on to say so they discussed the trends and the fact they hadn't been identified.

At that meeting, did anybody raise the issue of

Letby?

A. No.

Q. At this point, were you aware of allegations or concerns about Nurse Letby?

A. I wasn't aware about the allegations about Lucy Letby for quite some time. In fact, it was when the media were at the hospital, that was the first time I heard her name ever mentioned.

Q. So the first time you heard the name was after the police were involved?

A. Yes.

Q. Did anyone discuss at this meeting -- we have seen who were the attendees, did anyone discuss concerns that a nurse or a healthcare professional might be involved?

A. No.

Q. Having spotted at this stage, we have spoken about your awareness earlier, but in terms of a panel discussion at this stage discussing a trend, and we have talked about the training you had had in relation to Beverley Allitt, did anyone say: one of the areas we should look at is whether a healthcare professional might be involved?

A. No, they didn't. And I -- I think that was as I say probably borne out of the information that we

received, which didn't ever indicate that there was a concern and only indicated that the babies that we were informed about were very sick.

Q. Then looking, looking a bit further down, because there's -- one concern is -- is the trend that's clearly was discussed, or the failure to spot the trend and then it talks about the SUDI, Sudden Unexpected Death in Infancy and Childhood, it says:

"The panel discussed SUDI deaths within hospital and whether it was felt that deaths were not always treated with the same concern. If there was a concern over the death a SUDI protocol could be followed."

I mean, it's not whether there was a concern, it's when it was unexpected, the SUDiC process?

A. It should have been followed, absolutely.

Q. It seems to be saying there that there was a concern that that wasn't happening, is that your recollection of the meeting?

A. Yes, that's right.

Q. Knowing that the SUDiC procedure hadn't been followed, did that cause anyone to think: we very much need to look at this pattern because if that process hasn't been followed, the checks and balances that should follow an unexpected death are absent?

A. I -- I think at the time we were concerned

that the SUDiC wasn't followed because of lack of knowledge and lack of education primarily and it was after that that we did do some training around use of the SUDiC protocol.

I don't know why the SUDiC protocol wasn't followed because I would have thought that the paediatricians who were -- who were, you know, certifying a death or whatever it would be classed as should have spoken to Dr Mittal because he was the -- the designated doctor for safeguarding and child deaths and so he was the one who potentially could have said: you need to do a -- you need to follow the SUDiC protocol and have a Rapid Response Meeting.

Q. Was it any part of your role if you saw the word "unexpected" or "unexplained" death, was it any part of your role to check whether SUDiC processes were followed or not?

A. I would have spoken to Dr Mittal about that. There was some -- some areas in their SUDiC protocols actually have a clause that say something around if a child dies in hospital and they have previously been unwell, that you may not need to impose the SUDiC protocol but in Cheshire West that wasn't the case. Our SUDiC protocol, the LSCB SUDiC protocol in Pan Cheshire did specify that an unexpected death in hospital should

be -- should be followed, you should follow the SUDiC protocol.

Q. So although you weren't reviewing the Form Bs for the content, so to speak, as opposed to whether they were completed if you saw that alerted you to unexpected or unexplained you would have said?

A. I would have said to Dr Mittal what's -- you know, do we need to have a Rapid Review Meeting for this baby? You would have done without question. We had done that before. There was -- there were times where there was some confusion around unexpected or an unexpected death, not especially for the neonatal unit but just talking generally and we would discuss it and we would have, you know, that kind of dialogue between professionals and certainly it wasn't something that wasn't discussed generally.

Q. Do you recall raising whether SUDiC had been properly followed in relation to any of the indictment babies, any of the babies' forms we have looked through?

A. I think at that meeting we probably had quite a long discussion around this. I mean, it doesn't indicate how long the time is that this discussion went on for, but I suspect that we would have actually said what did the Form As say.

Q. Because at that point, the realisation had

occurred to the Child Death Overview Panel, had it, that --

A. Something was going.

Q. -- their process to spot patterns had failed?

A. It -- it had and actually even I -- I don't know even if we would have sent every single Form A to Pan-Cheshire, I don't know whether the trend would have been noticed from a little while because of the timeframe of child death reviews. It's a difficult question to answer that.

Q. Let's just follow through what happened to Child A because as well as these concerns about the trend and about the SUDiC process not being followed, this meeting actually looked at Child A because by the time -- this time the other investigations, the Coroner's process had ended.

So if we could go to page 11, we have the short summary of the cases that were considered and we have got Child A, so page 10, there and we see cause of death at the top: "unascertained" and at the bottom:

"Form C completed. Case closed. Unexpected death."

So there's an acknowledgement there by the panel having considered it's unascertained and unexpected and yet there was no SUDiC process for A and neither was one

initiated here. Do you know why that was?

A. No. I can, I -- I -- I don't know why that would be. I can only assume that at the time the paediatrician who certified the death must have made no indication that it was completely unexpected.

It would appear just reading that that maybe they had put on the Form A that the child was unwell prior to that, not -- not expected to die.

Q. But having just had a panel discussion that SUDiC wasn't being followed, having come to a conclusion that it wasn't, wasn't that the point to say: we need to now refer it?

A. Yes, you would think that -- that we should review that back, we absolutely should have done.

Q. And if we can just go on just to complete the picture to INQ 0001944, so this is the -- we look finally at Form C, so this is the end of A. So we had Form B where the information was sent and there was obviously a long -- Child A was one of the cases where there was a long pause before you came to consider it, you were considering it now it was considered on 24 March and we see case summary there and that in fact is just in fact copy pasted, it's from the Form B, it's the summary from Form B.

If we could go then to page 3, we see "Panel

discussion". The case had been delayed coming to panel, part of the neonatal review at the Countess of Chester. However, the outcome of the review did not find any issues with the death. The Coroner has given a verdict of unascertained and therefore the panel agreed the case could be closed.

Again, this was not ringing alarm bells at this stage?

A. I think potentially it may not have running alarm bells at that time. I mean, it's a difficult thing to look back but this will have been quite a long discussion. The -- the cases will have been presented by a paediatrician. The way that the panels worked was that if it was a neonatal death, for example, it would be one of the paediatricians who presented the case to panel and went through the Form As and the Form Bs and they will have -- my guess now is that some of the information from the Countess review would have also been available at that time and I suspect that the reason we didn't go back with that case to question the unexpected death was because it had been through that review process. And as it clearly says on here that they didn't find any issues with the death and so we have clearly concurred with them having looked at the Form As and the Form Bs with the information that was

available at that time.
Q. If we could just go on to page 5 then which is the final page of that form, we see how the Child Death Overview classified this death because -- and clearly the categorisation was important because that's also part of spotting patterns --
A. (Nods)
Q. -- to get the correct classifications and we see there that it has been classified as a perinatal neonatal Event 8?
A. And that would have --
Q. Why was it not 10, sudden unexpected, unexplained death?
A. That will have been because of the information that we had received. So if the information we had received on the Form A and Form Bs had not said "Sudden Unexpected Death", then that's not how it would have been -- and the actual CDOP had to categorise the death as the highest category that it was at the time.
Q. Well, we don't need to flick back, but the review we have just looked at --
A. I know it does actually say "unexpected death".
Q. Unascertained and unexpected?
A. I don't -- I can't answer why at that point as

a panel of 12, 15 people we came up with that. I -- I can't answer that.
The only thing I can think is that it was discussed in detail, it would have been presented by a paediatrician, we would have looked at the Royal College information as well, we would have scrutinised the Form As and the Form Bs and that would have been the reason for the categorisation.
But I understand what you are saying. And I understand that potentially it could have been 10. I think that the guidance for categorisation comes with whether is highest. So I assume that at the time having reviewed all the information, that was what we categorised it as because it was the highest category.
Q. Of course the category is significant because if it's been identified as a SUDiC, then there was the SUDiC process, which would have potentially involved the police.
A. Yes.
Q. So --
A. But the SUDiC process should have been long before the CDOP panel, it would not have been afterwards. The SUDiC process should actually be implemented at the time of death and that child death reviewed at a joint meeting with the police, with social

care, with everybody, usually within 48 hours of the death. So that doesn't happen after the CDOP panel. Because the CDOP panel meeting might be -- it could even be a year, it could be a long time, especially if there is going to be an Inquest, it could be a very long time after death.
Q. So the situation is, isn't it, Ms Dodd, that the CDOP panel at no point during this process either spotted a pattern or referred any of these the deaths that they were specifically considering Child A or Child I to the SUDiC process?
A. They wouldn't have done it at that point because the SUDiC process should have been implemented as soon as the child died. So doing it that far down the line is, is probably -- it may still be valuable, actually. When you think about it like that, it may still be valuable, but it's --
Q. Well, it may be valuable but at this point, the police hadn't become involved?
A. No and actually -- so I guess the police are there at the SUDiC -- at the CDOP panel meetings, the police are aware of -- of those deaths. It is a multi-agency meeting which is discussed in a multi-agency, a multi-professional way. So it's not down to one person to say what's happened, it's down to

that whole group of people.
MS BROWN: Yes, I have no further questions.
LADY JUSTICE THIRLWALL: Are there any other questions?
MS BROWN: I believe there are no questions from the Core Participants.
Questions by LADY JUSTICE THIRLWALL
LADY JUSTICE THIRLWALL: No, very well. There was just one thing.
Just one question, if I may, Ms Dodd, and it was going back to your discussions with Dr Mittal quite early on when you were at sort of three or four deaths and you say that "we may have discussed that there were three or four deaths", but I just wondered: do you have any memory of what you would have been discussing and why you would have even been discussing it?
A. I think -- well, I -- we did work very closely together.
LADY JUSTICE THIRLWALL: Yes.
A. And obviously we would be meeting for the CDOP panel meetings and within the hospital -- the hospital's small.
LADY JUSTICE THIRLWALL: Yes.
A. And, you know, any child death is devastating but actually to have three or four on our neonatal

unit -- well, I say "our" neonatal unit, it's not mine, generically speaking. It would be tragic.

And so I would probably say to him: oh you know, Rajiv, what's happening? You know, it's really sad, you know another -- another baby has died and that would probably be the context of the conversation. It wouldn't be a scrutiny from my part at that point.

LADY JUSTICE THIRLWALL: No.

A. I think it would probably just be that we are acknowledging that we have got some very sick babies and it's tragic that we have lost another one.

LADY JUSTICE THIRLWALL: Just stepping back now and doing the best that you can, I appreciate the looking back is always very difficult and putting yourself back. But you mentioned knowing about Beverley Allitt and the recommendation of the Clothier Inquiry?

A. Mm-hm.

LADY JUSTICE THIRLWALL: Have you ever been in a situation where it actually has come into your mind that maybe something's going on?

A. In my whole nursing career, I -- I don't think so. I have occasionally worked with people where I have thought their competence could be improved.

LADY JUSTICE THIRLWALL: Sure, yes.

A. And may have discussed that with my manager or

their supervisor. Even at the time of this -- of this time, I don't think at the time we ever thought that anybody could be doing something like that and --

LADY JUSTICE THIRLWALL: No, it is rather why I was asking if it ever occurred to you.

A. I think really that was also sort of supported by the fact that the information we received didn't indicate that there were any concerns. So whilst we had a lot of neonatal deaths, none of the information that we immediately received or we immediately had to hand gave us any indication that there was anything wrong and certainly nobody ever spoke about it, nobody ever said.

LADY JUSTICE THIRLWALL: You mentioned that and I absolutely understand --

A. Yes.

LADY JUSTICE THIRLWALL: -- what you say about that I was just wondering if there were any circumstances in which you ever thought the thing that may be unthinkable.

A. I have -- I have been aware of it but I have never thought about that in my -- there's never been a situation in my career where I have been seriously worried about a practitioner --

LADY JUSTICE THIRLWALL: Yes.

A. -- who may be causing harm.

LADY JUSTICE THIRLWALL: All right. That is very helpful.

A. Yes, I can't think -- as I say, I would -- there might be some competence issue, there might be something that would alert me to an issue with a practitioner that I might actually go to my manager or go to their manager and raise that, but I have never, ever thought that somebody is doing something unthinkable in an area that might have been working at that particular time.

LADY JUSTICE THIRLWALL: All right. Thank you very much indeed, Ms Dodd.

Do you have any other questions?

MS BROWN: No.

LADY JUSTICE THIRLWALL: No. Well, then I am happy to say, firstly, that we will take the break and come back at 25 to 12 and, secondly, that you are -- thank you very much for coming to give your evidence and you are free to go.

A. Thank you.

(11.18 am)

(A short break)

(11.35 am)

LADY JUSTICE THIRLWALL: Mr De La Poer.

MR DE LA POER: My Lady, our next witness is

Ms Hayley Frame and I wonder if she might come forward, please.

MS HAYLEY FRAME (sworn)

Questions by MR DE LA POER

LADY JUSTICE THIRLWALL: Thank you very much, do sit down.

MR DE LA POER: Please could you give us your full name?

A. Hayley Frame.

Q. Ms Frame, is it right that you provided to the Inquiry a witness statement dated 30 June of this year?

A. Yes.

Q. Is the content of that witness statement true to the best of your knowledge and belief?

A. Yes.

Q. By way of your background, did you qualify as a social worker in 1995?

A. That's true.

Q. Between 1995 and 2008, did you work in local authority children's social care?

A. Yes.

Q. Were you predominantly working in child protection or safeguarding?

A. Yes.

Q. Between 2008 to 2011, were you the child death

manager for Nottingham City Local Safeguarding Children Board?

A. I was.

Q. As part of that role, did you develop the Child Death Review process in that area?

A. Yes.

Q. Pausing there for a moment. In that role, how did you find the cross-boundary working, by which I mean the areas surrounding that and the liaison between theirs and yours?

A. Nottingham City is a unitary authority and then in terms of the cross-border, cross-authority it's with Nottinghamshire County Council, so the two councils work very closely together across the whole safeguarding agenda, they have joint safeguarding procedures.

When the requirement in 2008 was made for there to be the Child Death Review process, it was agreed that there would need to be very close working between Nottingham City and Nottinghamshire County Council because most of the deaths would have occurred in the city because that's where the hospital was, the larger teaching hospital.

So the -- all of the procedures were agreed jointly. Even deaths that occurred outside of the Nottingham City area would be referred into the

Nottingham City CDOP and we met jointly as a cross-authority CDOP twice yearly. We also looked at annual Thematic Reviews of neonatal deaths.

Q. In 2011, did you begin work as an independent Consultant?

A. Yes, I was self-employed for 11 years.

Q. As an independent Consultant, were you appointed to be the independent chair of the Pan-Cheshire Child Death Oversight Panel in 2015?

A. Yes.

Q. What you say in your witness statement was that your experience in Nottingham was key to that appointment?

A. Yes, and when I became self-employed in 2011, the bulk of my work that I was completing during that period of time was I was the independent reviewer for serious case reviews, domestic homicide reviews and safeguarding adult reviews and I was also the independent reviewer for drug-related deaths in Nottingham City.

So it wasn't just around the child death manager post that I had previously, it was in terms of my work in the reviewing of death and learning lessons and those statutory review processes.

So that -- that was my experience that I took when

I went to interview for the independent chair role.

I was also at that period of time providing expert witness assessments in Family Courts. So I suppose the point that I am -- I am stressing is that the independent chair role was one of many roles that I had during that period of time. It wasn't a full time job, it was chairing of meetings.

Q. How many hours per week or per month were you spending as the independent chair of the Pan-Cheshire CDOP?

A. When I first was recruited to that role there was a very large backlog of child deaths that hadn't been through the process, the CDOP process, going back years. So it was agreed that we would meet, it was quarterly was the frequency of the meetings, but it was agreed that we would meet every other month to try and clear some of the backlog.

Q. So you have a meeting every other month. Outside of that meeting, how much time were you devoting to it, did you have an allocation of time or was it as the job required?

A. As the job required. It was mainly, you know agreeing agenda setting, signing off of minutes, any actions that arose from the meeting that were assigned to me.

Q. Presumably scrutinising materials before a meeting took place?

A. Yes.

Q. Are you able to give us any estimate of the approximate number of hours outside of meetings that you were spending on a weekly or monthly basis?

A. A day a month would probably be a fair estimate.

Q. You have told us about the backlog and we will come back to that in a moment. But bearing in mind what you have reported to be a very positive experience in Nottingham about the cross-border cross-boundary working relationships, how did you find the Pan-Cheshire CDOP cross-boundary cross-border working relationships?

A. Well, I suppose by virtue of the fact it was the Pan-Cheshire CDOP so that was four LSCB areas coming together, that was to recognise the fact that in isolation the numbers of Child deaths would be so small that it would be very difficult to identify any patterns and trends from such a small cohort and also a number of the statutory services worked across those boundary areas so that is why the Pan Cheshire came together from the four LSCB areas.

In terms of liaison outside of that, there was the North West -- I'm sorry, my memory escapes me, I am sure

I refer to it in my statement. I never attended the meeting which is why I am probably not remembering.

Q. North West regional?

A. Yes, thank you. So that -- that was in place.

We didn't -- at that point the requirements under Working Together to Safeguard Children had changed so whereas when I worked in Nottingham there was an expectation that you would be -- the CDOP would be notified of all deaths in that area, regardless of home address. That changed. So in the Pan-Cheshire CDOP we were only notified of deaths of children whose parents were resident in that area. So any child that would have been outside of the CDOP -- Pan-Cheshire CDOP boundary we wouldn't have been notified of. So there was minimal liaison.

Q. Well, bearing in mind that change, doesn't that change reinforce the need for very strong communication to surrounding areas?

A. Yes.

Q. Was that something that as chair, you focused upon or tried to develop in any way over the time that you were chair?

A. No. And I -- the reason for that was that when I was appointed as the independent chair it was because there was a significant amount of work to do to

get the CDOP to be fit for purpose in many ways. That was around -- a lot of that was around the backlog.

The child death co-ordinator had only just started in post, there was a lot of work that needed to be done in terms of Terms of Reference, attendance, that -- there were certain things that the CDOP or the Child Death Review process didn't do. So, for example, it was well known from the outset that they weren't compliant in terms of Rapid Response arrangements at that point.

Q. Just pause there. Is that under the SUDiC process when you say Rapid Response?

A. Yes, yes, I think -- I think the terminologies changed. I haven't worked in the field of child deaths since 2017 so I think it's like a joint response, Isn't it.

Q. It is the Joint Agency Response, JAR?

A. Yes. Back then it was called a Rapid Response.

The profile of the CDOP the quality of the information being submitted on the Form Bs, there was a lot of work that needed to be done to just try and get it up to speed. The CDOP didn't review deaths of babies less than 23 weeks, even if they had taken a breath, which again wasn't compliant with the statutory guidance.

So there was a lot of work to do to correct those processes internally before thinking wider than that.

Q. When you say the Rapid Review process wasn't being instituted, was that across all sudden unexpected child deaths, so in the community, in hospital or were there particular pockets or areas that didn't seem to be triggering that process?

A. It was the issue around home visits. So the Rapid Response process is that the -- a relevant health professional, preferably a Consultant paediatrician, would do a joint visit with the police following an unexpected death.

Q. If I can just stop you there. You will appreciate the Inquiry's particular focus is upon hospitals?

A. Yes.

Q. So I hear what you say about where -- where that identified problem area was. Can I invite you to consider whether the issue about SUDiC and hospital deaths was that an issue that you perceived as existing when you took over as chair?

A. No, not when I took over, no, obviously there were discussions in relation to that into some of the panels that I chaired but no, not at the point that I took over.

Q. What was your understanding about whether or not there was a need for a Rapid Response Meeting under the SUDiC protocol if a baby was born in hospital and died on the neonatal unit?

A. If death was unexpected, then the same process applies. We had had these discussions in my previous role in Nottingham and we agreed that it would need to be looked at on a case-by-case basis and be a proportionate response, but that the process would still be followed nonetheless.

Q. So would that mean that as a very minimum that for every Sudden and Unexpected Death the designated doctor would be notified of that?

A. Yes, yes.

Q. And is it at that point that you were envisaging that there would be a discussion about whether or not that Rapid Response Meeting involving the other agencies should occur?

A. Yes.

Q. Now, we have already had explained to us the purpose of the Child Death Overview Panel. Can I just invite you to consider this in summary: was one of its main functions to look for trends or patterns?

A. Yes.

Q. In the two years that you were chair, were

there any -- and you don't need to list them, but were there any trends or patterns identified by the Child Death Overview Panel?

A. Not specifically in relation to neonatal deaths, no. We had a campaign around safe sleeping, we had lots of discussions around maternal smoking and obesity, so there -- definitely we were identifying some learning. But there wasn't -- it was very difficult in terms of like identifying trends because we were dealing with a backlog as well so we weren't reviewing the deaths in a timely way.

So that obviously skews the data as well.

Q. The fact that you were dealing with that backlog and the confusion that that might lead to or the uncertainty that might do, did that require quite a systematic approach where you started to populate things on a year-by-year basis so that you could make sure that you were getting a clear view of deaths in context?

A. I had to do a quarterly report, a quarterly chair's report which included the performance data.

Q. But if I can just stop you there. I am not just asking about reporting on the deaths that you were considering in that quarter but about putting those deaths into their proper context so that if they had

been -- taken 18 months to come through, that you were looking back to that earlier period to consider whether that death, at that time, formed part of a pattern; do you see?

A. Yes, I do.

Q. Do you see what I am saying?

A. I do.

Q. Yes, and did that process occur?

A. No, it didn't.

Q. Bearing in mind the obvious challenge of clearing a backlog, do you think on reflection that should have been something that was occurring as an additional part of the process of clearing the backlog?

A. Yes, I think that the driver was to just try and at least be -- there are statutory timescales in terms of the length of time it should take to review a death, and some of these deaths were like two years or more, so that the driver was to really try and get on top of it so that we could concentrate on the new notifications and complete those in a timely way.

There was, there wasn't -- there was no -- there wasn't an action log in place, for example. So when a child death was reviewed and there might be actions there was no mechanism to actually track those. So that

was another thing that I brought into place.

Q. In terms of the drivers that you have spoken about, to clear the backlog?

A. Yes.

Q. Just looking back on it reflectively, do you think there's any possibility that during the period that you were chair, there was perhaps too much focus on clearing the backlog so you could have a clean start and do it properly as you would want to as opposed to perhaps being as systematic as should have been the case with each of the backlog?

A. I believe that we still reviewed each death with the amount of attention that it needed, based on the information that CDOP was provided with. So it wasn't like it was rushed, hence why we increased the frequency of meetings.

But I suppose it did mean that the number of neonatal deaths was higher that we were reviewing as a CDOP because neonatal deaths fall into the greater category, the largest category anyway and so that would have felt like we were reviewing a lot of neonatal deaths and one of the things -- I am sure it's in one of the annual reports that I wrote -- talking about doing a Thematic Review, learning from what had happened in my previous roles in Nottingham and we also looked at the

modifiable factors of -- I can't remember which year it was, it might have been 13/14, we looked at all of the modifiable factors in terms of the actions relating to those to see what -- so the "so what" question: what happened? We made these recommendations as a CDOP and what action was taken to try and evidence the learning.

Q. Bearing in mind that the panel's function was to look for trends or patterns --

A. Mm-hm.

Q. -- was it necessary for concerns to be raised as part of the forms being filled in or did the panel also have a function to stand back and say: well, there are perhaps too many deaths in this area compared to our expectation, so in other words the raw data itself rather than the detail of each case, was that something the panel was concerned with?

A. The panel received that -- that data as part of my quarterly reports, so that had -- it had that data there in terms of the number of deaths reviewed. At no point were there any concerns raised in terms of clusters or -- or any patterns, no.

Q. But a cluster might be self-evident if you get a large number of deaths. Even if in the case of any given one of them, there is no specific concern raised, provided the panel is sighted on all of the deaths in

that cluster, might that be something that the panel notices and says we have had a surprising number of deaths?

A. Yes.

Q. That in itself is something that we need to investigate?

A. Yes, if they were notified of them all, absolutely.

Q. So in other words you are not solely reliant upon people raising individual concerns, you do have a step back and look at the overall --

A. Yes.

Q. -- picture --

A. Yes.

Q. -- role.

Now, a point you make a couple of times in your witness statement is that because of the way that the panel system was working at that time, not all of the deaths from the neonatal unit during the period we are focused on were deaths that the panel was scrutinising?

A. Yes, that's right.

Q. We know that in fact it is only Child A and Child I who were the subject of a panel meeting?

A. Mm-hm.

Q. The Inquiry has heard evidence from

Sharon Dodd this morning about the fact that all the Form As, regardless of whether or not the child ultimately was considered by the panel, passed through her hands, I think the exception being Child O and Child P, and that she kept a log or a tally.

Now, her evidence was that she didn't tell you about that. Do you have any recollection at all about those Form As and any tally being kept or record?

A. No.

Q. Is that something that you should have been told about, do you think?

A. I think it's difficult, isn't it, because there was no longer the statutory requirement for the CDOP that covers the area where a child died to be notified.

I think if -- if the concern is that there's actually a spike, then absolutely, then the CDOP should have had that discussion and I should have been notified. But there wasn't -- there wasn't a framework for that information to be routinely passed to the CDOP.

Q. In terms of your awareness of when there was -- that there had been an unexpected increase in the number of deaths on the Countess of Chester neonatal unit, when do you believe that was?

A. Because I -- because I was self-employed

I didn't have, like, agency records, I haven't had anything to go back to. So I have been trying to think about this and obviously reading through the documents that I have been sent, because there was mention of the review when we were considering one of those two children because there was a discussion around that child being part of the cohort of children that were subject to the review. So that must have been the first time I knew about it, thinking about it.

Q. So if I can just help you with that, that's a meeting that took place on 16 September and we are going to look at the detail of that meeting?

A. Okay, so that must be the first mention so -- I think. So that must have been when I first became aware that there was going to be a review. To be honest, I am just putting myself in my own shoes back then, given that more Thematic Reviews of neonatal deaths were seen as in a positive way because often with neonatal deaths, especially in cases of extreme prematurity, there hadn't any modifiable factors, there isn't huge amounts of learning, it's entirely due to a child's prematurity, so to look at them thematically in a larger cohort, and I think probably that is what I thought was happening at that stage.

And then I became aware -- I think it was around

the time that the report -- the report was going to be published because they had made recommendations in it for the CDOP, so there was email correspondence there before the meeting in March when we went through it, yes.

Q. Again we will come to that. But we will add some detail around your answers there very shortly. Before we get to that stage of the chronology, I would just like to take you, please, to an interview that Ms Dodd conducted, or was the subject of, with the RCPCH?

A. Okay.

Q. You have seen these notes already as part of your preparation but we will bring them up, INQ0014605 and we will go to page 21, please.

Now, Ms Dodd has given her best recollection of what these notes may mean or what she says about them so I am not going to ask you to interpret them, just to treat them on their face.

Firstly, we can see five lines down a reference I think to you, it is a misspelling but as chair of the CDOP and it would appear that Ms Dodd has suggested that you could be spoken to.

Do you think that the RCPCH, knowing what you do now, should have spoken to you as the chair of the CDOP?

A. Yes, and I think I would go further than that. I think that the CDOP and the wider LSCB should have been part of the Terms of Reference. It's -- the fact that that review was done completely in isolation and not in a wider partnership arrangement doesn't make sense to me.

Q. Now, again, we have heard what Ms Dodd's evidence is about this so I am not going to repeat that. But "CDOP not worried", just treating that on its face.

At this point, right at the beginning of September 2016, so before that meeting involving Child I, was CDOP -- you, the chair of CDOP, aware of the increase in mortality?

A. No. So I can only assume that's what that means, "CDOP not worried". Well, we didn't know we had anything to be worried about.

That -- that's my assumption. It's strange that -- the way it's set out, could talk to me, but then it talks about "CDOP not worried" as though they are two quite separate things. So I don't understand that but that can be my only sort of assumption.

Q. All that you can say is that it is literally right that CDOP wasn't worried but the reason for that is you didn't know?

A. Yes.

Q. Thank you very much indeed. We can take that down.

Just casting your mind back, did you know that Ms Dodd, who wasn't in fact interviewed in her capacity as her role on CDOP, but in fact an internal -- a paediatric liaison role that she had.

A. Okay.

Q. Did you know that she had been interviewed by the RCPCH?

A. I don't believe I did, no.

Q. Is that something that you should have been told as CDOP chair, do you think?

A. Not necessarily. I suppose we were just awaiting the findings of the report. We weren't involved in the -- you know, the mechanisms of the review. As I say, you know, now thinking about that we perhaps should have been, but we weren't and there was nothing, no one had raised that there was any concern.

So I suppose I didn't know that there was anything that needed to be scrutinised any further.

Q. Now, once Ms Dodd had been interviewed and it was plain that the RCPCH were there at the hospital investigating or conducting a review which arose out of an increase in the neonatal mortality rate, and it would appear that there was some discussion of CDOP, would you

have expected to have had a discussion following that with Ms Dodd so that she could tell you about the discussion that she had had and the fact that CDOP had come up?

A. Yes, and we may well have done. I just can't, I can't recall that we did. I have not worked in the, in the field of -- of Child Death Review since 2017 so in many ways, you know, I -- I don't have the recollection of whether we did or whether we didn't and I don't have any agency records to go back to look to see if we had that conversation. I don't remember having a conversation with her.

Q. Because if a review is being conducted which encompasses a number of deaths, would it not be quite important for CDOP to know that so that there could be a very clear understanding about whether any particular death that has already passed through CDOP, whether that was subject to the review at any future death that is going to pass through?

A. Yes, because thinking about it, you know, we perhaps should have shown more curiosity in terms of who are the children that are subject to this review and we didn't ask those questions.

Whether I think we should have done, it's difficult with sort of hindsight bias, isn't it, because we didn't

know that there was any reason to ask those extra questions. But looking back now it would have been, yes, if we had would have been involved in the Terms of Reference, if we knew the children, how many had come through Pan Cheshire CDOP, how many had gone to other CDOPs, then absolutely, that would have been helpful.

Q. We will look now at the meeting on 16 September, INQ00178115

Now, against your name for this meeting there is an R which, if we go over the page, signifies designated rep?

A. (Nods)

Q. Does that mean that you were representing somebody else or somebody else was representing you?

A. Dr Mittal chaired in my absence, I wasn't present.

Q. I think we can see that from the next line just below.

The fact that you weren't there, would you still have read the material ahead of the meeting?

A. Yes, and agreed the agenda.

Q. Agreed the agenda?

A. Mm-hm.

Q. Do you recall if you had any discussion with Dr Mittal ahead of the meeting given that he was

representing you?
A. I don't recall and I don't know why I wasn't there, if it had been -- if it was due to sickness and, you know, an urgent matter then probably not. But sometimes I couldn't attend because I was due to give evidence in court. So it -- I don't recall a conversation with him.
Q. Did you have a responsibility following the meeting even if you didn't attend to read the minutes and to understand what had happened?
A. Yes.
Q. As chair if you were concerned about anything that you saw on the minutes, would it be your place to raise that and say: I just need to understand what happened at the meeting because I don't agree with it or I can't --
A. Yes.
Q. I can't fathom it?
A. Yes.
Q. Now, in section 3 on this first page, we can see Child I's case was closed and:
"The child details to be sent to the Coroner for review of case notes. The child case to be referred to once the Royal College report is presented by Dr Mittal."

Now, this case, as we will see on the Form C, was closed at this meeting, effectively as I understand it, meaning that the all of the data had been taken that needed to be taken for the Form C and that could then be entered on to the database for the pattern recognition; is that right?
A. In part. And the reason I say that is because there were actions. So those actions would have then gone into the action log which was considered at every meeting.
So the actions you would send to the Coroner for review of the case notes, that would have led to an action being logged on the action log. So although the case was closed, that should have been ongoing.
Q. What would you expect to happen? If the child's details were sent to the Coroner for review of case notes, what in practice was that going to lead to?
A. I supposed -- just for assurance.
Q. So there was an expectation that the Coroner would receive that child's notes from CDOP regardless of whether they had otherwise seen anything about Child I's case and review them and comment upon them?
A. I assume so. It's difficult for me to -- I wasn't party to that discussion. But I assume that's what the thinking was.

Q. I mean, did you understand the Coroner to have an assurance role after a CDOP case was closed?
A. No. We were -- we had worked quite hard on improving our relationships with the Coroner's office and we had representation -- I wonder if we did at that one. No -- yes, in attendance Christine Hurst. Without being present I don't know if there was a conversation between Dr Mittal and Christine about what the Coroner could do to help, I don't know. But I am assuming it would be for a review for assurance.
Q. What also seems clear from the face of the minutes, and in fact we know, is that the College hadn't issued its report which incorporated its consideration of the period that Child I died during?
A. Mm-hm.
Q. Do you think that in fact it was inappropriate to close Child I's case whilst there was still a review that might shed some additional light which was ongoing?
A. Yes.
Q. Because as we have understood it, CDOP, as in the panel meeting, represents the very end of the Child Death Review process?
A. (Nods)
Q. And absolutely every investigation should have taken place and been resolved insofar as it could be by

the time that the panel closes the case; is that right?
A. Yes, that's correct.
Q. So on the face of it, that isn't what happened here.
Now, when you received these minutes, do you have a recollection of noting that point and wondering about it or having some curiosity about why a case has been closed in circumstances where firstly the Coroner appears to be looking at it, and the RCPCH still hasn't provided its report?
A. I don't, I don't recall and I know that's not particularly helpful but I absolutely don't. But that -- that would have been of concern, that is of concern. So I would have hoped that I would have queried that. Without seeing the action log, I don't know what -- what happened as a result of that.
But that would be unusual for the case to be closed and maybe I was assured by the action log, I don't know.
Q. It's unusual and sitting there now, although some time later, you don't have any recollection of having followed this up. Do you think that suggests that you probably didn't?
A. I -- I don't know. If I didn't then I should have done.
Q. Page 5, please, we will see --

LADY JUSTICE THIRLWALL: Have you finished with this point, Mr De La Poer?

MR DE LA POER: Of course my Lady.

LADY JUSTICE THIRLWALL: Are you continuing with the same point?

MR DE LA POER: No.

LADY JUSTICE THIRLWALL: I wonder if I might ask something. I'm sorry, would you mind just putting that page back up again? I just want to ask a question for clarification.

It's slightly odd to say -- if you look at the section 3 "Review of Children Cases", and then "3. Action: case deferred" and then we have "Action: closed case" rather than "case closed".

And are you there looking at or are they there looking at a case which has been closed because it then says "child's details to be sent to Coroner" etc, etc and if we look further down "Action: closed", a different child "the CCG to be contacted to ensure that the RCA report" et cetera. Then the following one "closed case" "The conclusion of the Inquest report to be added to the Form C".

What's not clear to me, having looked at them all while you are being asked about questions of the others, is what's being described there, information that's

going to be put into the files, where the cases have already been closed or do you always go closed and then add things to them?

A. No. I think it's -- it's the case was closed. That was the --

LADY JUSTICE THIRLWALL: That was the action in that meeting?

A. Yes, yes, close the case.

LADY JUSTICE THIRLWALL: So all of those cases --

A. Yes.

LADY JUSTICE THIRLWALL: -- the cases were closed but with something else that has to be done?

A. So it might be where there was information hadn't been put in the right form, so "the conclusion of the Inquest report to be added to the Form C". So that's obviously information that we had hadn't been input to the Form C.

LADY JUSTICE THIRLWALL: But when was that going to be done, after the case was closed or before the case was closed?

A. Yes, so that would be what the CDOP administrator/co-ordinator would do.

LADY JUSTICE THIRLWALL: Would have done.

A. In fact, yes, the actions -- those actions are for her.

LADY JUSTICE THIRLWALL: Just so I understand it, although a case was closed, in all of these examples further action was to be taken to complete the file in some way or another?

A. Yes, there might still be actions, yes.

LADY JUSTICE THIRLWALL: Yes. Well, if Mr De La Poer wants to explore that any further obviously he will do, but that is sufficient for my purposes, thank you.

MR DE LA POER: My Lady, I certainly had in mind to ask Dr Mittal about that.

LADY JUSTICE THIRLWALL: Yes, I thought you might. Yes.

MR DE LA POER: Page 5, please, we will look at what is said about Child I. We can see a little more detail about the Royal College. In fact it says in terms:

"This child's death is subject to review at the Countess by the Royal College."

So not just the period during which that child died, but that child's death itself?

A. Mm-hm.

Q. Is that even greater cause for concern for you looking at this that it would appear that there is a direct investigation going on into that child's death

in circumstances where simultaneously the panel is closing the case?

A. I suppose there's two -- two parts to that, isn't there? We didn't -- I didn't know as the Chair of the panel and it wasn't discussed within panel, so my assumption is that most panel members equally were unaware that there was a concern.

So this child's death being subject to that review, given that there wasn't a concern about the review, probably meant that that didn't trigger any further discussion or scrutiny.

However, the point is the same; that if a child's death is being subject to a parallel process, a review, then it shouldn't have been closed.

Q. We can see that there is an action which includes an item for:

"The next panel meeting to discuss if unexpected deaths in hospital should be considered for an RR meetings, the child to be referred to once the Royal College report is presented by Dr Mittal"?

A. Mm-hm.

Q. Now, you have told us that in your mind there should always be an initiation of the SUDiC process --

A. Yes.

Q. -- in the event that the death is unexpected,

even in a hospital. Does it surprise you that that appears to need to be a subject for discussion as opposed to: this is what the protocol is, we all just need to get on with it?

A. I think seeing it in the context of even in unexpected deaths, the Rapid Response -- in the community, the Rapid Response process wasn't being followed.

It just -- it just felt for me that there was so much that wasn't in place that should have been in place. You know, in other areas they will have a rota of on-call paediatricians so in the event of a -- you know, an unexpected death in the community or in hospital, that person will be contacted out of hours. That starts the process.

There was lots of discussions and a business case put together with various different options for to be taken to the CCG, as was, around how we were going to meet that need within Pan-Cheshire because it was a funding issue.

So there was so much that wasn't in place that should have been and was in other areas. So I suppose was I surprised that the Rapid Response process didn't happen for unexpected deaths in hospital? Probably not, because it wasn't happening robustly in the community

either. Well one, that, that element of a home visit, a joint home visit not being completed.

Q. Well, at all events it appears apparent from this record that in the context of Child I's case there is a discussion about the SUDiC protocol and we will just briefly look at the Form C for Child I, INQ0001946.

We can see the start of the case summary has that word "Sudden"?

A. Yes, yes.

Q. So on the face of it, a clue, would you agree, that this child's death ought to have been the subject of SUDiC?

A. Yes.

Q. If we look at page 3, we can see under the issues identified the same terms which appear in the summary there about the RRM.

Then finally if we go to page 5, I am just going to ask you a question that Ms Dodd was asked about, this tick box?

A. It's wrongly categorised.

Q. Well, exactly so.

Now I appreciate this isn't your meeting in the sense that you weren't there, but we have seen that there was plainly a discussion about RRM and sudden and unexpected, we can see the word "sudden" appears on the

face of it and item 10, do you agree, appears to fit that?

A. Yes.

Q. Now, a point that Ms Dodd made and I seek your help on, if you look right at the top it says:

"The classification is hierarchal. Where more than one category could reasonably be applied, the highest up the list should be marked."

A. Yes.

Q. What was your understanding of how this form operated and how it was in a hierarchy and what was it trying to get at by ranking these different descriptors?

A. Well, these were national descriptors and set out in that order. So that would have been Department of Health at the time, I suppose.

When you look at it, it reads almost -- you start with what's potentially a safeguarding or a crime, don't you? It's deliberate inflicted injury, abuse or neglect. And then sort of go down in terms of moving more into conditions relating to the child.

But if that was the case, if we were going from, you know, conditions related to the child, chronic medical conditions, cancer, up to trauma and inflicted, you would think that sudden and unexpected, unexplained death would be higher up, wouldn't you, because we don't

know why that child's died? It is always at the bottom and that doesn't really make a great deal of sense looking at it now.

What Sharon said is right, absolutely, the highest up the list should be marked but it's the wrong category. It should be -- it should be 10.

Q. If one thinks about it in terms of the taking a step back role that CDOP had, lots of sudden, unexplained, unascertained deaths might be thought to be a major red flag; do you agree?

A. If there were lots of them.

Q. If there were lots?

A. Yes.

Q. But if consistently, as you point out, you are moving up the hierarchy because you might reasonably describe it as one higher up, you are going to miss that big picture because that -- that box 10 isn't going to be ticked in necessarily every case it could be?

A. I suppose the other thing to remember, though, is by this point, because it is at the conclusion of the Child Death Review process, whether that was expected or unexpected death, we should know the cause of death so that's what this -- this -- this category is around.

So you may have an unexpected death but the process itself, the Rapid Review process, has determined that it

was due to infection or it was due to a chronic medical condition that people weren't aware of. So that -- that would be -- if you knew the cause you would then tick that box.

Q. Well --

A. You wouldn't because every unexpected death, the purpose of the process is to establish the cause. So that might not be the case, you wouldn't tick that box for every single unexpected death.

Q. If I can just pause you there. In Child I's case, at this time, there was a cause of death that was given, we have seen that in the form?

A. Extreme prematurity was part of it, I think, wasn't it?

Q. Yes?

A. Yes, so that would be why the panel will have lended themselves to 8.

Q. Thank you. We can take this down, we are going to move forward a few days to 26 September. And on this date, there was the Cheshire West Local Safeguarding Children's Board meeting and I believe you presented a draft CDOP annual report to that meeting, and I just want to ask you, please, about the circumstances before that meeting.

These minutes were produced presumably within

a relatively short period of time of 16 September, was that the process?

A. It -- it didn't take the administrator huge amounts of time to create the minutes, no.

Q. I suppose the question really comes down to this: would you have expected to have seen those minutes by the time you went to that safeguarding meeting?

A. What's the time difference between the two meetings?

Q. We have got 10 days.

A. Probably not.

Q. Probably not?

A. No.

Q. So does it follow from that that you don't think that you would necessarily have been aware of what was said at the meeting you didn't attend about the Royal College report?

A. Yes.

Q. In which case we can shortcut this. The draft report that you presented makes no mention --

A. No.

Q. -- of an increase in mortality. Is the explanation for that based on what you have just told us that you at that point, 26 September of 2016, didn't know?

A. I didn't know.

Q. I mean, had you known is that something that you would have included in the report?

A. Probably not. Only as much as I would -- we would need more information and the annual report is talking about the previous year's performance as opposed to any current.

Q. Well it's 2015 to 16, the sudden unexpected increase in the neonatal mortality rate began in June 2015, so will have fallen within the period for your draft annual report?

A. Had I known that then yes, it would have been included.

Q. Moving forward to 3 October. INQ0012781. Again we don't need to look at all of the detail of this because you have had an opportunity to refresh yourself and I would like it deal with it by way of summary.

We can see that Ms Eardley has sent an email to -- presumably that is the CDOP general inbox that it's gone to? We don't see the whole of it there but --

A. (Nods)

Q. -- it's not with your name on it?

A. No, it's the inbox that Ann McKenzie had control over.

Q. And it is addressed to Ms McKenzie/you on the

face of it?

A. Yes.

Q. And in that email, Ms Eardley points out that the RCPCH has been looking at the relatively high number of deaths during that period, June 15 to July 2016, and asking for you to share the CDOP report.

Of course, that CDOP report doesn't make any mention of it because you didn't know anything about it?

A. No.

Q. And also flagging in the second paragraph the need for a more systematic approach to neonatal deaths. We know that that turned out in the report as saying you need to follow the SUDiC protocol?

A. (Nods)

Q. If we just go over the page to put the balance of the email in. And we can see there a little bit more information about what is effectively going to the SUDiC issue because it's about the definition of what is an unexpected death.

And asking this question: how deeply the CDOP considers these deaths in terms of investigation recommendations given that many are unlikely to have a direct safeguarding element?

A. Mm-hm.

Q. Flagging that there are 11 deaths which

presumably at the time you would have recognised as being a significant number coming from the Countess of Chester?

A. Yes. I don't believe I ever saw this email.

Q. We are going to come to that. But in terms of the face of it, that seems to be what Ms Eardley is asking about.

A. Yes.

Q. If we go back up a page, we can see that Ms Eardley follows up on the 17th to the same inbox asking whether there is a chance to have a look at it and it also appears that she's telephoned because she says: I have also left a message.

Now, that telephone number, is that just a generic inbox, mailbox?

A. It would be the number for Ann McKenzie.

Q. And the following day, a response from Ms McKenzie talking about just one part of her email, namely the annual report, saying it hasn't been signed off yet, but not dealing with a number of other matters raised by Ms Eardley?

A. No.

Q. Now, you have just said a moment ago that you don't believe you saw this email. Should you have been shown this email?

A. Yes.

Q. And was that a satisfactory response that Ms Eardley received to all of issues that she was raising?

A. No. It -- it just dealt with the annual report, didn't it, not the other issues.

Q. But we can see that one of the things that Ms Eardley is raising is the RCPCH's concern about the SUDiC process?

A. (Nods)

Q. Well, we will see that theme developing?

A. Yes.

Q. It was mentioned, as you will recall, in the 16 September meeting that you didn't attend.

Let's move forward -- thank you, we can take that down -- to the meeting on 20 November, INQ0017817.

As that's coming up, you will recall at the previous meeting they parked the SUDiC issue to this meeting, which is the one that follows?

A. (Nods)

Q. We can see that you do attend this meeting towards the top right-hand corner. On page 2, some discussion about the SUDiC issue and it's headed specifically item 4 "SUDiC within hospital".

"Should a Rapid Response Meeting be held each time

there is a Sudden Unexpected Death within a hospital? The meeting felt that the response should be on a case-by-case basis and the safeguarding doctor should be involved in the discussion with a designated doctor and a Rapid Response should be arranged if deemed appropriate. The meeting felt this process should be reflected in our procedures with clarification of best practice."

So again, you talked about the other problems with the SUDiC process in the community but this appears to be a discussion focused upon SUDiC in hospitals?

A. Mm-hm.

Q. Do you have a recollection of this discussion?

A. I am just reading around it to see if it ...

Yes, because I am sure we were talking about awaiting the Kennedy report and updating the procedures.

Q. The Kennedy report, being the updated RCPCH --

A. Yes.

Q. -- guidance which came out in late 2016?

A. '16, yes.

Q. But to your mind was there in fact on the existing guidance any doubt that at the very least the designated doctor should be contacted?

A. No.

Q. There should be a proper discussion --

A. Yes.

Q. -- about whether or not the Rapid Response Meeting needed to be convened?

A. Yes.

LADY JUSTICE THIRLWALL: That sounds rather like what you described in Nottingham.

A. Sorry?

LADY JUSTICE THIRLWALL: Is that rather like what you have described that you did in Nottingham?

A. Yes.

LADY JUSTICE THIRLWALL: Yes.

MR DE LA POER: If we go back up the page just to the first page. We can see that Dr Mittal is present at this meeting.

A. Mm-hm.

Q. Do you recall what his point of view was about the fact that effectively a discussion ought to take place with him for Chester every time there was a Sudden and Unexpected Death and that there should be a discussion about the Rapid Review Meeting?

A. I don't recall what his views were in that meeting. But based on the -- based on the minutes of the discussion I would make, I would assume that he was in agreement with that.

Q. Now, at the previous meeting, the fact that

there had been an increase in the number of deaths on the neonatal unit was flagged because there was reference to the Royal College report. I mean, at this meeting was there any discussion directly with Dr Mittal about well, what did you do during that spike? Were you involved? Did you talk about Rapid Review?

A. I still don't think even at this stage that we knew that there was a -- that there was cause for concern.

We were just waiting for the report and it did -- when I think back that probably was quite passive, we were waiting for this report, I suppose we trusted in the process that it had been, you know, obviously experts in the field would be completing this review and we were just waiting for that.

So no, there weren't any the conversations took place after the -- after the report was received.

Q. Now, you have characterised that as being perhaps a bit passive and you have also made the point that there were no concerns flagged to you.

But isn't a cluster in itself something that you should have been absolutely focused upon? So cluster that's taken place in your area, some of the babies that you are going to look at or have looked at form part of that cluster? Just help us to understand why it is that

you think that that wasn't something that was being discussed?

A. Because the action was for there to be an independent review commissioned. So we were assured by that action. So -- and that that review would identify the cause of the cluster. So that's why we were waiting.

Q. So let's come to that report now. We can take that down. We know in early February 2017 what is called the dissemination copy of the Royal College report was published by the Countess. For your purpose you don't need to worry about the difference between the two versions that existed.

Was that a report that you saw at the time that it was published or that was drawn to your attention?

A. I saw I think I saw it around February time.

Q. Early 2017, that is when it was published, yes?

A. Yes, because I remember -- I don't know if Ann had sent it to me but it was a really poorly scanned copy so then I went online to try and find it myself on the website and it was the same poorly scanned copy so yes, it had been published, not long after it had been published.

Q. INQ0001954, page 20. Now, we can see here

towards the second half of the page, firstly, that there is a concern that CDOP did not appear to be alert to the cluster of neonatal deaths and for at least some there should have been a Rapid Response Meeting within five working days of notification, so's effectively a criticism of the failure to provide the SUDiC process?

A. Yes.

Q. And that there is a recommendation directed effectively to you and your panel that:

"CDOP should consider whether its processes could have detected cluster of deaths and initiated external review more swiftly"?

A. Yes.

Q. Now, a number of questions around that recommendation. Firstly, upon the evidence, it would appear that some of the Executives at least within the Countess of Chester received this report before Christmas of 2016, so in other words it wasn't published for at least a couple of months after they had it?

A. (Nods)

Q. From your point of view as CDOP chair, how important was it that you knew about this recommendation made directly to you as soon as possible?

A. Hugely important.

Q. Because this was in fact the very thing that

your panel had been discussing in September and November and this was separate and independent confirmation that there was a problem --

A. Problem.

Q. -- with the approach that the Countess was taking.

Did you ever follow up this particular recommendation in terms of looking at your processes and how it might detect a cluster and why it didn't?

A. Yes, that was discussed at the next CDOP panel meeting.

Q. So we will come to that in March.

A. And I think I had a conversation with Fiona Harvey as well, didn't I, around that time.

Q. I'm sorry, Fiona?

A. Is it Fiona Harvey? No, it's not. Fiona ... Reynolds.

Q. And what was your discussion with Fiona Reynolds?

A. Around that -- the recommendation.

Q. Bearing in mind that you will have been aware in general terms that the review had taken place -- the visit for the review had taken place in September because we can see that in the minutes of the 16 September the first discussions taking place, did you

wonder why it had taken the best part of six months for this report to be produced into the public domain and into your hands?

A. No, I didn't. Do you mean upon receipt of the report?

Q. Yes, upon receipt of the report?

A. Sorry.

Q. Did you think: gosh, that's taken a very long time, I probably ought to find out why it's taken that long?

A. No. I didn't.

Q. So let's move forward to the CDOP meeting on 24 March. INQ0001953.

A. I do recall thinking -- remembering -- why haven't they come and spoken to us?

Q. Who do you mean by "they"?

A. The Review Team because obviously they were talking about the process and talking about the role of CDOP but no discussions had with myself.

Q. Even at this stage were you unaware that Ms Dodd had had a short conversation with them and discussed CDOP?

A. I don't believe I was aware of that.

Q. I am not suggesting that should have been the totality, I think your evidence was that you should have

been spoken to?

A. Yes.

Q. So this is the meeting on 24 March. We can see that you are present, Dr Mittal is present, as are a number of other people including, as he was, detective chief superintendent Nigel Wenham?

A. Mm-hm.

Q. In fact I think is Detective Superintendent there.

If we go over the page to page 3, we can see that most of the page is devoted to the neonatal review and was this the first time that you gained further detail around what had taken place in the review and why it had been commissioned, or had you had any prior notification?

A. I had had the report but this was the first time there was a discussion. My copy's a bit blurry, I don't -- here.

Q. I think that that's as we hold it, so I apologise --

A. Okay.

Q. -- but we will do our best with it. Do you recall who made this presentation?

A. It's so unfortunate that it's not minuted particularly well. I am assuming it was Dr Mittal. But

that's an assumption.

Q. We see the initials "GF" and at times "Gill Frame"?

A. Yes.

Q. Now, who was she and why was she at the meeting?

A. So Gill Frame was the independent chair of the Local Safeguarding Children Board and she had had some conversations, I believe, with the Medical Director of the hospital and she was aware of this recommendation around the CDOP processes, so she wanted to come along to this -- have this discussion around what action we needed to take.

There was a suggestion that because the -- the review hadn't looked at the children's individual case notes that the Child Death Overview Panel would do that, but then Gill Frame had -- who was not related to me in any way by the way, Gill Frame had I believe spoken to the Medical Director and that was already being completed.

So the discussion was around we would want to have sight of that as a CDOP to provide independent scrutiny. So it's a result of the report, its recommendations, any action we needed to take that Gill suggested that she came to that panel. She wouldn't ordinarily be there.

Q. She made a request of you in the last sentence, it would appear to:

"... write to Alison Kelly outlining the recommendations the panel have made and confirm that the panel would not have had oversight of the death and an update to be added to the chair's report"?

A. Mm-hm.

Q. Can you shed any light on that and what, if anything, happened as a result?

A. Okay, this was as a result of the CDOP not being notified of all of the deaths so we didn't have that information over that period of time.

If that action was there for me to write to Alison Kelly, I will have written to Alison Kelly. The -- I -- it would be the CDOP administrator that would have copies of those letters because I -- you know, I didn't even have a secure email account at this -- you know, I wasn't a member of staff so I can't look to see if that letter was written and sent but I am assuming that it -- it would have been because I wouldn't have left that action outstanding.

Q. We can see over the page that there is at item 7 further discussion about SUDiC in the context of a hospital and an unexpected death, so again it appears that that was also something that was under discussion

separately at the meeting?
A. Yes.
Q. Then finally for this meeting, if we go to page 10 --
A. I mean, there is another action there on 4 for to write a letter. I remember writing that one, I don't know why I can't recall writing the other, but I am certain that I would have done.
LADY JUSTICE THIRLWALL: Is that the one at the top of the page, the action?
A. There was -- no, it was relating to something else, it was around child protection concerns.
MR DE LA POER: Now, at the top, this is Child I's(sic) case, as I understand it. We can see the cause of death is unascertained and that there was an inquest and further this case has been delayed coming to panel as it was part of the neonatal review of COSH and the case was closed unexpected death.
Just a few points coming out of that. We know that the Inquest for Child A took place on 10 October of 2016 which means that following that there was an opportunity at least to discuss Child A's case on 20 November when CDOP met and on 20 January of 2017, when CDOP met. But it's not in fact until this meeting that Child A's case was discussed.

Do you know the reason for that?
A. Cases didn't come to CDOP until the Form B was fully populated, so that would probably be the reason.
Q. Isn't the Form B populated before the inquest takes place at the time of death?
A. I -- I --
Q. So the inquest had taken place on 10 October 2016. The death was in fact in October 2015.
A. Yes.
Q. I am just wondering --
A. Why the delay.
Q. Why -- why did it take effectively until the third meeting after that inquest had been completed that CDOP was discussing the case, whether you have any insight into that?
A. I -- I don't know the -- I don't know.
I -- I would assume it would be around information not being gathered from all of the organisations, from all of the agencies. Often we had to send things back, the information wasn't sufficiently detailed or there was gaps. So it would take a long time to get something ready to -- and perhaps there might be because obviously it's -- the modifiable factors might be held within agency records that wouldn't necessarily form part of an inquest so I suppose that's why.

Q. Let's look briefly at the Form C for Child A. INQ0001944.
LADY JUSTICE THIRLWALL: Just while that's coming up, Mr De La Poer, when you introduced this document you said it was Child I.
MR DE LA POER: Did I?
LADY JUSTICE THIRLWALL: Just for the shorthand writer.
MR DE LA POER: No, that is entirely my error.
This is Child A.
LADY JUSTICE THIRLWALL: Yes, you have made it clear since. It's just for the record.
MR DE LA POER: Thank you very much, yes.
So this is the Form C. Do you know when this form would have been completed?
A. So what would happen is Ms McKenzie would pre-populate some of this, but it would be, the Form C would be completed in the meeting. But the cause of death, the case summary that would have already been completed and the list of anonymised documents will already have been -- she, she would collate everything into a combined Form B, so the front sheet essentially.
Q. So we have got the cause of death "unascertained" at the top and if we go to page 3, we will see that panel discussion as before under "Issues

identified", a confirmation of that verdict, unascertained, and following that:
"... and therefore the panel agreed that the case could be closed."
Now just help us to understand the approach of the panel. We have got: in the case of Child A, it's gone all the way through the inquest process, the cause of death is "unascertained". It was a Sudden Unexpected Death. You know that the SUDiC process was not applied as it should have been in Child A's case because you know by this stage that the Countess wasn't doing that. You have had no further light shed on why Child A died by the Royal College review.
Was it the right thing to do to close Child A's case at this point or should the panel have thought about whether further information should be sought and if so from whom?
A. I suppose again the panel would be reliant upon a concern being raised with them. So if the Coroner had raised concerns, had the designated doctor raised concerns, I mean obviously the police were present in that meeting too, weren't they? I -- I think that in cases such as this a neonatal death would be assumed to be the -- the cause.
I'm assuming that's what's ticked on the next page.

Q. Well, if we go to page 5, we can see --
A. Yes.
Q. -- "perinatal neonatal event" and let's just have a look at the text of that:
"Death ultimately related to perinatal events."
And some examples are given and what is included in that definition is also given. Now, the Coroner had conducted a full inquest and had reached a narrative verdict that said death was -- cause of death was unascertained. I mean, in reality, was that a box that could be ticked in this case because there was no information to say that it did relate to perinatal events?
A. So if that was the professional judgment of the panel --
Q. But --
A. -- but in terms of categorisation, I mean it's stated, isn't it, "unascertained" in 10.
Q. Well, it's repeated throughout the documentation this is an unascertained death.
And so I appreciate this is a panel decision, but it needs to be hung on something, doesn't it? There needs to be something within the information that the panel can say, "This was a perinatal event that caused this death."

And having had your chance to look at it all now and focus upon it, can you point to any perinatal event that applied in Child A's case?
A. Can we go back to the first, the front sheet, please?
Q. Yes, page 1.
A. The panel was very reliant on the designated doctors that were part of that panel to interpret medical information to us.
But, the cause of death was unascertained, so that should have transferred through to the final box on the -- the form.
Q. Now, we've got one more matter to discuss briefly but before we come to it, I would just like to pause now.
As part of this meeting where Child A's death was -- case was closed and where the Countess was discussed, we saw on that page that Ian Harvey was to be invited to the next --
A. Yes.
Q. -- CDOP meeting, which was due to take place in June. If I can just provide you with a bit more information, some of which you may already know.
We know that the Consultants raised in June of 2016 their concern that a member of staff may be responsible

for the deaths?
A. Mm-hm.
Q. Was that something that you were ever told?
A. Never, until the meeting that I attended at the hospital.
Q. Which we will come to in a moment, 27 April.
A. (Nods)
Q. Should you have been told that?
A. Yes.
Q. Why do you say you should have been told that?
A. The Child Death Overview Panel needed -- should have been notified of all of the deaths and should have been notified of the concerns. Obviously the police sit on the Child Death Overview Panel.
However, there were other people that should have been informed before me, so that, you know, if there was those concerns they should have been reported to the police at the time, the local authority should have been informed, so that their Local Authority Designated Officer would be involved because it's a person working in a position of trust, so there were other investigative processes if those were the concerns that should have been the priority.
My -- I would have wanted to know because of my role in terms of chairing the Child Death Overview

Panel.
Q. And whose responsibility was it, was there any particular person with any particular role who had a responsibility to tell you?
A. To tell me?
Q. To tell the panel, yes, about these concerns?
A. I don't know how much the designated doctor was aware because obviously he was a panel member.
Q. Well, if I just pause you there. We will hear from Dr Mittal on Wednesday.
But do I infer correctly from your answer that what you are saying is that the designated doctor is the conduit that you would expect such information to be passed to the CDOP?
A. Yes.
Q. Well, we will hear from Dr Mittal about what he did and didn't know.
A. However, that doesn't take away the need to escalate if you are feeling that your concerns aren't being heard or are being blocked.
You know any, every -- Working Together to Safeguard Children is really clear in terms of safeguarding being everybody's business and those concerns could have been reported to the police and the local authority by anybody working within that hospital.

Q. We are going to come now just to the final meeting that I am going to ask you about. You tell us in your witness statement that you had a telephone conversation with Mr Harvey on 20 April?

A. Yes.

Q. And I will just remind you of what you say:

"Mr Harvey stated that he was keen to learn lessons and wanted to be transparent in terms of the neonatal deaths within the hospital, hence contacting me in my role as CDOP chair. I believe we had a conversation about the modified Rapid Response for unexpected deaths in the hospital going forward. I recall Mr Harvey talked about the RCPCH report and they were assured that there was nothing to be concerned about but going forward the hospital would escalate any concerns to the CDOP in a timely way."

A. Yes, because they hadn't.

Q. Because they hadn't.

Now, in that meeting, did he tell you what concerns hadn't been escalated in a timely way?

A. No. It was a very brief phone call.

Q. But did he give you to understand that there were some concerns that he wanted to tell you about?

A. It -- no. It's as a result of the recommendation in the report about the hospital not

escalating. The conversation that I had had with Fiona Reynolds, which again was around the hospital not escalating the concerns, and the discussion that had taken place in the Child Death Overview Panel.

So it was on the back -- it was, that's what he was referring to; that they hadn't raised any concerns with the CDOP around the cluster of deaths in a timely way and that they would do so going forward.

Q. Were you then asked to attend a meeting on 27 April?

A. Yes.

Q. And were you asked if you wished to bring anybody else from the panel with you?

A. Yes, because it was just a meeting that I was invited to initially.

Q. And did you decide to bring Detective Superintendent Wenham?

A. Yes.

Q. And, briefly, why did you choose a police officer?

A. Firstly, as a member of the Child Death Overview Panel because the question was whether I wanted to bring anyone else from the Child Death Overview Panel and I suppose given that it was in respect of child deaths, from my point of view the three key agencies are

health, police, local authority. I may well be the independent chair but I am a social worker.

So that would seem, if we are going to be talking about any concerns in relation to deaths, we would have the three key agencies there.

So that's why I asked if Nigel would come with me.

Q. As you know, we have Detective Superintendent Wenham's notes of that meeting. Have you had a chance to look over those?

A. Yes.

Q. And do they accord with your recollection of what was said?

A. I don't remember any reference to angel of death and I think, I think I would. It may be that that happened at the end of the meeting and I wasn't ...

I don't know. But I don't, I don't recall that.

Q. But other than that detail, do those notes represent your recollection?

A. It's far more detail than I recalled because I suppose the meeting very much was reassuring that, you know, there had been this thorough investigation and review they had looked at the case notes as well now; nothing of concern.

And then it shifted when there was this -- it was stated that there was -- they have looked at rotas,

staff rotas and that there was one member of staff who was on shift during each collapse and it was a note -- and then of course you're thinking: What, what are we being told here? This, this is gravely concerning.

So all of Nigel's notes, which obviously I am assuming were contemporaneous notes that he was taking, around everything before that I don't remember that. What I remember vividly is that conversation and then it being clear that the reviews that had taken place so far hadn't ruled out anything untoward.

Q. What you tell us in your witness statement is that Dr Jayaram -- well, you tell us. What was Dr Jayaram's position in that meeting about whether further investigations were required?

A. Yes, he felt that they, they did.

Q. And what was agreed between you and Detective Superintendent Wenham about what would happen next by the end of the meeting?

A. It was agreed that -- so Nigel spoke about how this was very much a matter for his officers, that they needed to secure case files and then I think he was -- he had another meeting some time after that and that obviously started the investigation.

But I was clear coming out of that meeting that there was something very worrying and Nigel had the same

view and the fact that this was the first time that we knew this.

Q. Were you given any explanation as to why you had not been told until that point?

A. Not that I recall.

MR DE LA POER: Ms Frame, thank you for answering my questions. My Lady, those are all that I have for this witness.

LADY JUSTICE THIRLWALL: There are no more from anyone else?

MR DE LA POER: No.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: No, and I have no questions -- no, there was one thing actually, sorry, and it's really an administrative point.

You have said a number of times that you were an independent chair, so self-employed and you had no access to the systems that everybody else was using.

A. No.

LADY JUSTICE THIRLWALL: So how were you given information?

A. So I think the -- it was like a secure portal. I'm sure it was called Cryptshare. So the papers for the meeting would be sent to me, I could then read them, but then they -- so I wouldn't be able to access them

now because it would time out in terms of the secure link to it. So that's how I received papers.

Often I would travel to Sandbach and meet with Ann and we would go through things face to face. But, yes, that was an ongoing challenge because I wasn't an employee, I didn't have a secure email address.

LADY JUSTICE THIRLWALL: That's what I was about to ask you. Could you receive emails?

A. As long as it didn't contain any identifying information, then everything else would go via the Cryptshare. So this is why I have sort of struggled to go back and see did I send that letter, because it would be sat on a system in Chester's local authority.

LADY JUSTICE THIRLWALL: Yes, I understand that --

A. Yes.

LADY JUSTICE THIRLWALL: -- from the perspective of trying to put together a statement. But in terms of doing the role, was that a disadvantage, not having, you know --

A. Yes.

LADY JUSTICE THIRLWALL: -- the usual communication channels?

A. Yes, I think so and not being able to look at data, I suppose. You know, not being able to -- it wasn't there at my fingertips, I would have to request

something.

LADY JUSTICE THIRLWALL: And so in terms of --

A. That was a challenge.

LADY JUSTICE THIRLWALL: Thank you. So in terms of looking at something on the portal, you could look at it obviously while you were online, but there was no -- were you permitted to download things from the portal and keep them?

A. No, I never did.

LADY JUSTICE THIRLWALL: No. All right.

Thank you. Sorry, Mr De La Poer, is there anything you want to add to that?

MR DE LA POER: Not at all. No, thank you, my Lady.

LADY JUSTICE THIRLWALL: No. In that case we will rise now and start again at five past 2. Thank you very much indeed for coming. You are free to go now.

(1.04 pm)

(The luncheon adjournment)

(2.05 pm)

LADY JUSTICE THIRLWALL: Ms Brown.

MS BROWN: If we could call Ms Sindall, please.

LADY JUSTICE THIRLWALL: Would you like to come forward.

MS PAULA SINDALL (affirmed)

Questions by MS BROWN

LADY JUSTICE THIRLWALL: Do sit down.

A. Thank you.

MS BROWN: Could you please give your full name?

A. It's Paula Margaret Sindall.

Q. I think at the time of the events we are looking at, your name was Paula Lewis?

A. That's correct.

Q. You have provided a statement to the Inquiry dated 29 May 2024, is that true to the best of your knowledge and belief?

A. Yes, it is.

Q. Turning to your qualifications, you qualified as a Registered General Nurse in 1985 and worked on as a nurse on medical and surgical wards and on intensive care; is that correct?

A. That's correct.

Q. Did you ever work on a neonatal unit?

A. No.

Q. You qualified as a health visitor in 1992?

A. Yes.

Q. And then worked in the community as a health visitor and that I believe involved working with families where there were some safeguarding concerns?

A. Yes.
Q. In terms of your employment with the Countess of Chester Hospital, in 2009 you started working at the Countess as a full time Band 6 nursing post, I think later promoted to Band 7.
That role was to support Karen Milne, who was the named lead for safeguarding children and domestic abuse?
A. That's correct.
Q. If we could just very briefly look at the safeguarding team at the Countess of Chester at that time. Alison Kelly the Director of Nursing, she was the Executive lead for safeguarding children?
A. Yes.
Q. What was the extent of the contact you had with Alison Kelly in relation to safeguarding issues?
A. She was always the Chair at the Safeguarding Strategy Board meetings, so I knew her then, but apart from that my direct management was -- responsibility, my manager was Karen Milne.
Q. Yes, so you would -- if you had an issue it was Karen Milne you would be speaking to; you wouldn't be discussing day-to-day safeguarding issues with Alison Kelly?
A. No.
Q. Do you yourself ever refer an individual case

to Alison Kelly?
A. I'm sorry?
Q. Do you yourself ever referring an individual case to Alison Kelly?
A. The only time I may have referred something directly or informed Alison Kelly indirectly about something was in Karen Milne's absence. If she was not available and there was what I considered to be an important issue occurring in the hospital, I would email Alison Kelly to inform her.
Q. But there's -- just to be clear, there is no issue related to what we are looking at in this Inquiry where you contacted Alison Kelly about?
A. No, none.
Q. In terms then, so Alison Kelly as the Executive lead, then Karen Milne you have spoken about, who was the designated nurse?
A. She was the named nurse and named professional.
Q. She was your immediate boss?
A. She was my immediate manager.
Q. In terms of the paediatricians there was Dr Mittal who was the designated doctor for safeguarding?
A. Correct.

Q. I think he was the doctor on the Child Death Overview Panel and also had responsibility for the Sudden Unexpected Death in Childhood process?
A. Yes, he did.
Q. Then Dr Isaac had responsibility -- she was the named doctor for safeguarding children and had responsibility for supporting medical staff, particularly the paediatricians, in terms of their safeguarding responsibilities?
A. Yes.
Q. In terms of the two designated roles, Karen Milne and Dr Mittal, how did they --
A. Karen Milne had a -- was the named role, the designated nurse sat with the CCG.
Q. Sorry, the named nurse. Her interaction with Dr Mittal, how did that operate?
A. It was a professional relationship. We could communicate with Dr Mittal and -- if we needed to.
Q. In terms of other individuals involved with safeguarding, we have seen that there are nurses, for example on the Accident and Emergency Department, who would spend some days with the safeguarding team in order to take expertise and safeguarding into the Accident and Emergency Department?
A. Yes, she spent one day a fortnight with us so

that she had those additional skills and knowledge.
Q. That was Vivien Beswick?
A. That's correct.
Q. Then in terms of other individuals with some involvement, there would have been -- we don't need to go through the names but people who had some involvement in domestic violence, children in care, adult safeguarding, those would be the other sort of people other roles in safeguarding that would be attached to your unit.
A. In safeguarding but the adult safeguarding was separate to the children's safeguarding team.
Q. So in terms of the children's safeguarding team, we have got the two paediatricians, Dr Mittal, Dr Isaac, yourself and Karen Milne and Alison Kelly as Executive lead, so a relatively small team?
A. Yes, I think so.
Q. Did you consider that that was a sufficient sized team to manage the caseload that you had to manage?
A. No, it would be my opinion really that it wasn't. I think we were an unusual set-up within the Countess in that Karen Milne had a dual role as both the named midwife for safeguarding and the named professional for safeguarding. In other Trusts they had

two distinct roles with the named midwife and the named professional but Karen carried out responsibilities of both of those roles on four days a week and I thought that that was -- that put a lot of pressure on her and on the team really in terms of resource.

Q. So what did you consider was in fact required in terms of staffing levels within the safeguarding team?

A. Well, I left my role in the safeguarding team in 2022 and the size of the team at the point that I left was greatly increased from how it was in 2015 and has continued to increase since.

Q. So just talking about when you left, "greatly increased", what do you mean by that, doubled?

A. So three times the number of hours in the safeguarding children team as it stands now compared to how it was in 2015.

Q. Given the size of the team when you were there, what was the extent of the discussions between the four of you, did that mean there were a lot of discussions, were you a close team?

A. Well, I shared an office with Karen, we were -- Karen was responsible for my supervision and we had day-to-day informal supervision, if you like, if -- if I had any queries, we worked very closely together.

The paediatricians, the named and the designated nurse -- doctors weren't -- weren't in the same office as us, they were situated with the paediatricians.

But they were accessible, we could walk to their office and discuss any issues but we tended to communicate with them mainly by email.

Q. How often would you meet as a group or would you meet as a group, the four of you?

A. Really the only time I think that we met as a group was at the Safeguarding Strategy Board meeting.

Q. Did that cause a problem in terms of you being kept up to speed with safeguarding issues, looking back now?

A. I don't think so. I don't know what I don't know. So I am fairly sure that -- you know, that Dr Isaac and Dr Mittal would -- you know, they were mainly responsible, I think, for supporting the paediatricians and I wasn't party to how that took place.

Q. And in terms of your -- now looking at your day-to-day role, you refer in your statement to responding to enquiries and concerns raised by staff, would that be safeguarding concerns raised by either doctors or nurses?

A. Mainly nurses. Other therapists, although

people throughout the Trust as well as nursing staff, occasionally I would have a query from one of the paediatricians. The community paediatricians would more frequently make contact to discuss concerns.

But it was mainly the nursing staff and the other professionals apart from the medical staff.

Q. Was that because doctors would tend to go to Dr Isaac; is that your understanding?

A. I don't know but, but that would be my assumption.

Q. In practice, would that be nurses coming to your office or would you be going to the ward when they raised a query? How would it work in practice?

A. Well, we had a formal referral process. But we also -- so we would pick up daily referrals, we also had a telephone, a designated telephone with an answer phone facility, so 3 am messages were not unheard of. We also carried a bleep as well. But we were actually only on site in office hours.

Q. You say as well in your statement you had an open-door policy and that you and Karen Milne strove to maintain a very visible presence across the hospital. In practice, how were you doing that, how were you maintaining a visible presence?

A. It was -- well, I used to call and pick up the

referrals from A&E every morning, we tried to call into the children's unit every morning as well.

Q. Just stopping there for a moment, obviously we are very interested in the neonatal ward. How often would you visit the neonatal ward?

A. We -- we visited -- I didn't -- we didn't visit the neonatal unit unless somebody raised a concern but we were geographically situated very near to both the children's unit and the neonatal unit.

I can't remember but I think in 2015 we were actually on the corridor between the two, between the children's unit and the neonatal unit. We moved upstairs but we were still in the women and children's building.

Q. So whereas you would go to the paediatric ward on a regular basis, on a daily basis --

A. Yes.

Q. -- the neonatal was as and when you were requested to go there?

A. Yes.

Q. Approximately how often would that be, do you think? Once a month, once a week?

A. Probably at least once a week. And we tended to attend meetings regularly on the neonatal unit in relation to babies that were being discharged home where

there were some level of safeguarding concern.
Q. The sort of safeguarding concern that you were coming across most frequently in terms of the neonatal ward, what would that have been?
A. Sometimes it was about babies that we knew there were safeguarding concerns antenatally and those babies were now born and on the neonatal unit so we would be helping the staff to manage the safeguarding aspects and the safe discharge from the neonatal unit. But sometimes it would be that there were babies that weren't known to our team but a concern had arisen on the neonatal unit, for example there may have been some interactions between parents that had caused concern or some aggressive behaviour or something like that and the neonatal unit would seek support from us in -- in dealing with that from a safeguarding perspective.
Q. So broadly the safeguarding concerns were ones that were concerns about parenting of the child when discharged to that home environment?
A. If the -- sometimes we had babies on there who weren't going to be going home with parents and occasionally we used the neonatal unit as a safe place for this child to remain until the local authority could obtain the necessarily legal orders for discharge but -- but otherwise it was mainly about concerns within the

family and to make sure the baby was being safely discharged into their care.
Q. You say in your statement that you would visit the A&E and the children's unit in response to safeguarding concerns which is obviously a reactive-- when you were called --
A. Yes.
Q. -- you went, but you are saying that you would go as a matter of course every day, would you, in any event or would you just go when there was a requirement?
A. To the neonatal unit?
Q. No, to the A&E and the children's ward?
A. In 2015 the referral process to our team from A&E was a paper-based process, so we had to go into the -- to pick up those referrals. It's not now, it's electronic, but 2015 it wasn't.
Q. What about poster campaigns, other ways in which you would raise the profile of safeguarding, were any of those means employed?
A. Every clinical area was required to have a Safeguarding Board and the neonatal unit had one, the paediatric unit had one, A&E, and all the adult wards as well on which was detailed what to do if you feel a child's being abused. The flowchart -- I don't know if you have seen that, and the policy --

Q. Yes, we are aware of that.
A. That was on there, we would put regular updates on there, contact numbers. We also sent out communications electronically about new initiatives within safeguarding that we felt the staff needed to be aware of.
Q. In terms of those notice boards was there ever any notices that you put up that dealt in particular with concerns that individual may have about a member of staff, healthcare staff, working with children?
A. Allegations?
Q. Yes.
A. Not that I -- not that I recall.
Q. Training, if we can turn to that. One of your roles was delivering face-to-face safeguarding training from staff. It appears from your statement that that was in fact a major part of your role; is that fair?
A. Yes. There's a mandatory requirement for all staff across the hospital to have a level of safeguarding children training. So our Group 3 staff had face-to-face training --
Q. Just --
A. -- in addition.
Q. So we understand that Group 3 staff, that those are charged with regular contact with children and

families, so neonatal staff would be Group 3?
A. Group 3, yes.
Q. In terms of the training, you say that Karen Milne, she would do some of the training as well; is that right?
A. Well, Karen Milne designed the training and the content of the training but she wouldn't have had the capacity. We used to deliver training separately to the midwives and midwifery and Karen would deliver that training and then the rest of the -- the Group 3 staff across the Trust, I would deliver that. We called that the generic safeguarding children training.
Q. You say it was Karen Milne who was responsible for the content of the training, what input did you have as to deciding the content of the training?
A. Well, when -- Karen updated the training annually and -- and I always understood the rationale between what was included in that training and could make suggestions if I -- if I was -- if I wanted to, if I felt there was an issue that I had become aware of that needed to be included, but it was Karen that determined the content.
Q. But I think it was Karen Milne, your boss, and she gave the safeguarding training to the senior Executives, to Ian Harvey and Tony Chambers. Why was

she delivering that training, not you?
A. It would have just been that she had the capacity to do so and that was the best use of the resources at that particular time.
Q. But the training would have been in a sense standardised training, the standard safeguarding training, would it?
A. I -- I am not -- I have seen only from the package what was in the training that went to the Executives and I think that was -- I think the Executives have a Level 1 training, it wasn't a Group 3 training.
Q. In terms of Dr Isaac and the training, we have seen some PowerPoints that you, it appears, delivered some of the training with Dr Isaac. She was -- was she generally providing the training to doctors and you generally to nurses, was there that divide or --
A. Usually, yes. Some of the paediatricians did attend the generic training events that I put on as well, but mainly I think it was Dr Isaac that delivered to the paediatricians.
Q. From looking at the PowerPoints in broad terms, it appears that the training given to doctors and the training given to nurses, say for example doctors may be referred to the GMC, for example, but broadly the

training was the same for Group 3; was that your understanding?
A. I wasn't always aware of the content of the training that Dr Isaac was delivering, it wasn't -- I think we had delivered joint training a couple of times only but in between, I -- I wasn't aware of what training.
Q. When you did deliver joint training, was the training that she was giving consistent with the training that you were giving broadly to nurses?
A. It was definitely in my opinion more focused towards paediatricians and their responsibilities towards non-accidental injuries. The training that I delivered to staff didn't just feature -- didn't feature that as heavily and can I just say the -- the training that I delivered had to be delivered to a broad group of people who would be attending and so it would be that there might be bits in the training that were relevant to some staff, yet other staff would need more in certain areas and so, you know, I would always have to signpost staff to where they could get additional training as per their clinical role.
Q. But the Group 3 staff, so those involved with children on a day-to-day basis, they would be given specific training for their -- for Group 3 staff?

A. For Group 3 staff, yes.
Q. In terms of training to people who were not healthcare professionals, so for example Non-Executive Directors or volunteers, were you involved in training in terms of safeguarding any of those individuals or were you just focused on healthcare professionals?
A. Just focused on healthcare professionals.
Q. Just so we can have an overview of the training that was compulsory at this time, you address this in your statement and you say Group 3 staff, so that would be the staff working on the neonatal unit, whether nurses or doctors, they had to have Level 3 annual face-to-face training?
A. They had to have Level 3 but in addition they had to do the e-learning Group 2 because there is a requirement within the intercollegiate document for them to have so many hours of training so they completed the Group 2 e-learning and in addition annually Group 3.
Q. The e-learning, that was once every three years, that was a more --
A. That was once every three years.
Q. In terms of the frequency that you were putting on this training, how often were you putting on the training, how far often was there an opportunity to go --

A. Monthly.
Q. Was that because of the turnover of staff?
A. The turnover of staff and the fact that obviously staff work weekends, nights and what have you. So they had to have an opportunity for it to fit in with their -- their working patterns, really.
Q. In terms of compliance, so the fact that staff had to do this training, you say that in terms -- in 2015/2016, the Group 3 staff, compliance targets were 80%. Now, 80% doing the training of course means 20% were not. So one in five were not. Did you consider 80% was an appropriate target?
A. At the time, I -- I didn't question it and it was subsequently raised by the CCG. It was a target set by the CCG for us to achieve.
Q. You say you didn't question it at the time. Looking back now, do you think 80% was adequate for -- this is training for staff who are working on a regular basis with children?
A. I think it had to take into consideration people who were on maternity leave, people who were on long-term sick leave, turnover of staff, I thought at the time 80% was -- was reasonable.
Q. In terms of compliance, that was managed by staff managers, so on a -- for nurses that would be the

ward manager, would it?
A. Yes. And I think the experience would be when they had their annual appraisal that there's a part of the appraisal would consider whether or not staff were compliant with their mandatory training requirements which would include safeguarding children.
Q. But that compliance, who had trained, who hadn't trained and what consequences there were of not training, that wasn't something that you got involved in?
A. No. We sent the figures to the HR training department who then shared the figures with the managers in the clinical areas.
Q. So you recorded in effect who attended training and then you sent on those figures for someone else to deal with?
A. Yes.
Q. You talk as well about a bi-monthly review of safeguarding issues and training that was done, you refer to a paediatric peer review by Dr Isaac. That was every two months, was it?
A. I --
Q. About?
A. I recollect that it was every month -- every other month but I can't be 100% sure on that.

Q. That training, that was training where they would consider cases that had been dealt with the hospital and the learning obtained from those cases; is that correct?
A. That was my understanding. I attended I think two of those peer review because we were invited but our caseload was -- so our workload was so heavy at times that I couldn't often attend.
Q. Because if those bi-monthly meetings were looking at the learning from the cases and your work pressures meant that you could only do so infrequently, was that a concern, does it mean that you weren't in fact involved in the learning from cases that came in?
A. A lot of the learning for the peer review sessions that I attended was around how the medical staff had managed the cases in terms of investigations, looking at X-rays. It seemed to be very medically orientated.
Q. But in terms of if you were the port of first call some of the safeguarding would it not have been important that you as the safeguarding team were on top of the current issues that were coming through the hospital?
A. I think if -- if we ever had a child that was attending where there were safeguarding concerns that

required medical input, we would be involving the named doctor for safeguarding anyway as a matter of course.
Q. The fact that you say you weren't able to attend those meetings because of caseload, is that an indication perhaps that the team was overstretched?
A. In my opinion, yes.
Q. Just looking at external training, you represented the hospital at the Local Safeguarding Children Board Training and Development sub group.
What was the purpose of that group?
A. The purpose of that group was to pick up sort of lessons to look at multi-agency training that was available, to consider lessons and whether the lessons from events that had happened should be included in training and what kind of training that -- that would take.
Q. Did that -- you say multi-agency, did that training look at issues such as the requisite level of concern needed before going to the police, would that be something that would be covered in that training?
A. I -- no, I wasn't aware of that. I never came across that training.
Q. What about training about in what circumstances the Local Authority Designated Officer, the LADO, should be informed about a member of staff,

concerns about a member of staff; would that be covered in that training?
A. No, I already -- that was in Working Together. So we were already aware of what the requirements around referral to LADO was and it was in our Safeguarding Children policy.
Q. In terms of the Group 3 staff, and you have spoken about the fact they needed to do the two and a half to three hours face-to-face training and e-learning, would they also attend -- I think they could attend the LSCB training. Was that something that regularly in fact occurred, that staff would incur this additional training?
A. Yes, yes we had staff that maybe had dealt with a case around, for example, domestic abuse and the impact on children and the LSCB hosted additional training on that. There was additional -- the LSCB had a very good -- we had a link on our intranet to the LSCB training that our staff could access, so there was very good training on female genital mutilation, lots of additional skills that our staff might have felt relevant to them in their role.
Q. So that additional training was available but it wasn't monitored who was doing it; is that correct?
A. That's correct.

Q. In terms of your liaison role, you talk about liaising with other agencies and you speak particularly about -- that that involved liaising with the police.

What was your understanding about the level of concern you needed before the police could be contacted in a situation where you were concerned about potential harm to a child?

A. Well, I was aware of what was in the safeguarding policy at that time and in Working Together around if there was a concern about a child, a deliberate harm to a child that that would necessitate a referral to the LADO and that would then involve a strategy discussion about whether the police should be involved at that point that you didn't need to wait for the outcome of an investigation. The LADO wouldn't do an investigation anyway, she would oversee a process but you shouldn't wait for the outcome of an investigation before you make that contact.

Q. So to paraphrase, tell me if I am wrong, your understanding was where you had a concern you referred that and you didn't need to wait for an outcome, you didn't need evidence; it was a concern that triggered it?

A. You didn't need evidence. That wouldn't be something that I would do. I mean if -- if that had

come to me in my role as a Band 7, I would have escalated it to Karen Milne and would have expected an escalation then to the Executive lead for safeguarding and a strategy discussion fairly quickly and referral to possibly the police but definitely to the LADO would be a part of that strategy discussion.

Q. So if someone had come to you and said "well, I have got a concern but I have no evidence", you would have put them right that that was not the safeguarding approach?

A. Yes.

Q. In terms of contact with the LADO, you say that you had contact with the LADO about safeguarding concerns from other agencies but you never made a referral to the LADO yourself. We know in the case concerning Letby that it was eventually Alison Kelly who referred Letby to the LADO, but that didn't occur until 27 March 2018.

Did you consider that referral of a member of staff to the LADO was something that had to be dealt with at an Executive level or was that something that you -- you could have done? Or indeed anyone could have done?

A. I think that if -- I think it would have to be done with the -- with knowledge of the Executive lead for safeguarding, it's quite a serious thing to do and

so there would definitely would have had to have been some discussion with the Executive lead for safeguarding.

Q. If we can just look at some areas of policy then. You have referred a few times to Working Together so if we could just turn to INQ0014575 at page 54. So this is --

A. Sorry, my screen --

Q. It will come up.

LADY JUSTICE THIRLWALL: It just takes a few seconds.

MS BROWN: It just takes a little moment.

What you are going to see coming up in a moment is an extract from Working Together that sets out the requirements the obligations placed on the NHS under section 11 of the Children Act 2004.

A. Yes.

Q. The third bullet point down, the third black dot says there clear policies, so the obligation is to provide clear policies in line with those from the LSCB for dealing with allegations against people who work with children.

Then it goes on to say what an allegation is:

"An allegation may relate to a person who works with children who has behaved in a way that has harmed

a child or may have harmed a child, possibly committed a criminal offence or related to a child or behaved towards a child or children in a way that indicates they may pose a risk."

So that I think is what you were explaining; that it's suspicions, it's may have harmed, may pose a risk?

A. Yes.

Q. That would was the test, where you have got concerns about someone working with children?

A. Yes.

Q. If we can go then to the hospital safeguarding policy to see how it was set out there. If we could turn to INQ0014165. This is -- it went through a number of drafts but this is the Safeguarding and Promoting the Welfare of Children policy that is going to come up on your screen in a moment.

If we can go there to page 3 first. We see there this policy at the top, under the Executive introduction:

"This policy reflects the standards set in the Cheshire Local Safeguarding Children Board, the LSCB, manual of procedures."

Going down:

"Every adult has a responsibility to protect children and as employees of the Trust we are duty bound

always to act in the best interests of a child about whom we may have concerns."

We see then this is the September 2015 policy and signed by Alison Kelly?

A. (Nods)

Q. Who makes clear is the Director of Nursing and the Executive lead for safeguarding children.

If we can go on then to page 4. It says there a phrase that we have heard in this Inquiry: professionals needed -- this is under where it says "Serious case review", professionals needed to think the unthinkable?

A. Yes.

Q. Were you aware of the case of Beverley Allitt?

A. Yes.

Q. Were you aware of Recommendation 13 -- you may not know the number but the principal recommendation -- one of the recommendations of the Clothier Inquiry into Beverley Allitt that her actions should serve to heighten awareness in all those caring for children of the possibility of malevolent intervention as a cause of unexplained clinical events?

A. Yes.

Q. You say yourself in your statement at paragraph 35 that:

"For such a vulnerable children to come to harm at the hands of someone entrusted to care for them is horrifying and has resulted in staff such as me having to think the unthinkable."

That rather suggests that in 2015 and 2016, you weren't focused or maybe were not sufficiently alert to the possibility that a member of staff could harm a child. Is that the case?

A. No and I think that that comment in my -- at 35 it should have had: staff such as me having to think the unthinkable again. I don't believe that I wasn't thinking the unthinkable in 2015.

Q. In 2015/2016 you recognised, did you, that suspicions about a nurse harming babies, if that had been communicated to you was a safeguarding issue and that that should have triggered safeguarding processes?

A. I would agree with that.

Q. Because we have heard from a significant number of witnesses to the Inquiry who said that they received no training on what to do if they had concerns about a staff member harming a child and certainly from going through the PowerPoints, it doesn't appear that there's any reference to the possibility of harm by a healthcare professional or what steps to take if there were such concerns?

A. I think there was a certain, although we, the policy was -- the training was updated annually, there was the core part of the training that talked about professional responsibilities and talked about harm and what would constitute harm and it wasn't explicit at that -- within that about who would cause the harm.

Q. Looking back now, given that phrase "think the unthinkable", given the evidence that people find that a difficult concept, to imagine that a nurse or a healthcare professional might be harming babies, and given the learning from Beverley Allitt, looking back now, should that have been made more explicit in the training?

A. I'm not sure about referral to Beverley Allitt and I guess that was in 1991, 1994 the Clothier report.

Maybe we should have included a scenario that involved where a child had been harmed by a professional but in terms of children that come to harm, significant harm and are killed, they are much more likely to be harmed by people within the family or more recently a greater awareness of extra familial harm rather than harmed by somebody tasked with -- with caring for them within the --

Q. So the training focused on the more likely scenarios and didn't in fact cover this unlikely

scenario?

A. That would be correct.

Q. If we can just go back to the policy and if we can go to now page 30. So this there under the italicised paragraph, the next paragraph down, it says:

"If at any point a member of the Countess of Chester staff feels that their concerns about a child are not being acted upon appropriately, they must discuss this with the safeguarding children team who will take responsibility for ensuring the case is appropriately managed."

This, from what we can see, wasn't explicitly covered in the training and we know in fact that staff at certain points did have concerns that their concerns weren't being acted upon appropriately and didn't come to you as the safeguarding team. Why do you think that was? Why did that -- that system fail it is in the policy that if you have got concerns and you don't feel it is being appropriately managed, you come to safeguarding team and no one did come to you -- to the safeguarding team about those concerns; that is correct, is it?

A. That is correct, yes.

Q. Do you think looking.back. there is a reason for that, why that mechanism wasn't working?

A. I think I have learnt a lot from reading the transcripts as they have gone on. But I think the paediatricians were following the Speak Out Safely guidance and -- and that.

Q. If you could just maybe confine it to what -- why you feel as a trainer at the time people weren't coming to the safeguarding team with this concern?

A. I -- I don't know and I'm surprised.

Q. If we can go then down because this then does -- to pre-empt you -- talk about the Speak Out Safely policy and it stays there:

"From time to time staff may have concerns about care or treatment given to any patient."

And it goes on:

"Managers have a particular responsibility to protect patients and to handle concerns about their care in a way that will encourage the voicing of genuine misgivings while at the same time protecting staff against unfounded allegations."

So it does -- this policy does envisage the possibility of allegations against staff but this policy itself doesn't set out what to do, a step by step guide about what to do if you had concerns about staff?

A. No, it doesn't.

Q. And as far as you are aware, was there any

training or guidance or flowchart that set that out?

A. There were -- I thought there was a link, actually, to the allegations policy, the LSCB allegations policy.

Q. Yes, yes. So we see the LSCB, but in terms of the training that was given to Countess of Chester by the safeguarding team?

A. No.

Q. If we could then just turn over to page 32, we see under the heading "Human Resources Department" --

A. Yes.

Q. -- "The Trust will act with speed to any allegations of professional abuse. The Countess of Chester will identify a senior manager who will have responsibility for referral and ongoing liaison with the Local Area Designated Officer regarding any allegation made against a Countess of Chester member of staff."

I think you have already said that referral to the LADO wasn't something that was in the training, the Group 3 training, safeguarding training?

A. No.

Q. In this case, we know that the referral to the LADO happened at a very late stage, 2018?

A. (Nods)

Q. Do you have any explanation as to why? We

will see your statement, you say that your response, had you been aware of these concerns, would have been to go to the LADO; that's not what happened here?

A. Mm-hm.

Q. We are trying to understand why what thought was instinctive as a safeguarder didn't happen in practice. Can you shed any light on that?

A. I don't know that. I mean, all I would think as well in that a two and a half to three hour training it is very difficult to cover every single eventuality and scenario and the -- you know, as part of the training we always signposted staff and made sure they were aware of the policies that supported safeguarding across the Trust.

But why? So I don't know whether staff don't read policies. That would be a possibility. And I am not -- you know, because it was in the Speak Out Safely, there was information about the LADO in that as well and very clear about the times when a referral to LADO must be made. Yet I don't know.

Q. When you became aware -- and we will come to that in a moment, but when you became aware of the concerns about Letby, and I think we will see that but that was shortly I think you say before the police were involved, so late, but nevertheless a year before the

recommended, the information was sent to the LADO, did you not think at that point: we need to take this to the LADO, I need to make sure that this is being done?

A. I can't remember the exact timeline but I think --

Q. Well, the timeline is that we will come to it but you were aware, it seems from your statement, shortly before the police were involved, so 2017, spring 2017?

A. (Nods)

Q. And the referral to the LADO took place in 2018, I think March 2018.

A. Right, okay.

Q. So a year later in effect.

A. I think that I assumed then that once the police were involved, that the appropriate processes in terms of investigation would be taking place.

Q. If we can just go to some of the PowerPoints -- one of the PowerPoints. So INQ0108339. So what's going to come up here is a PowerPoint in a moment, this is a 2013 one, this has been picked because this is a Group 3 one. There is a number of PowerPoints, I think you have seen?

A. Yes.

Q. All slightly, slightly different but the key

slides remain the same. If we can go to page 2, we can see there the requirements, just to reinforce what you have said, that Group 3 staff need to complete the Level 2 e-learning model every three years and attend a face-to-face training session each year and the 80% compliance is set out there.

If we can then go to page 5. We see the principles that you have referred to from Working Together that everyone shares a responsibility for safeguarding and promoting the welfare of children irrespective of individual roles and that obviously was a key part of your training; that's correct?

A. (Nods)

Q. Then if we can look at 6, page 6, the last bullet point on that:

"It is simpler to lift the telephone than live with the regret of not doing so."

To what extent was that part of a discussion, that bullet point, of the point we have been discussing, that you don't need proof but once you have got a concern, you should act? Is that the point that's being made in that bullet point?

A. Yes. I would rather if someone had a concern that they pick it up and discuss it with us before we decided if it met a threshold to take additional

actions.

Q. So that can go down now. So to witnesses who say that they couldn't take action without proof, you would say, would you, that to some extent when we see that bullet point that was something that was covered in your training, albeit not explicitly in relation to staff members but the idea of acting picking up the phone as a principle was something that was covered?

A. Yes. Can I say as well if we are looking at training, that we have made the point that staff -- Group 3 staff also had to do the Level 2 e-learning.

Q. Yes.

A. Now, the Level 2 e-learning, Level 2 staff, one of the core competencies per intercollegiate guidance is that they understand professional abuse. I don't know whether the Level 2 e-learning addressed professional abuse, I don't know what the content of that training was. So we can't just assume that because it wasn't in the face-to-face training that it wasn't in the Level 2 e-learning.

Q. Would it not have been important for you to understand what was in the e-training so that you --

A. I -- I did the e-learning training but I can't remember in 2015 whether it covered professional abuse, I'm sorry.

Q. What do you consider would have been the correct response if a nurse or a doctor had come to you saying they had concerns about a nurse, because they were always on duty when there were unexpected and unexplained deaths? What as a safeguarder would you have said to that?

A. It would have set a level of concern but it could be at that point if they were always on duty when, when there was an unexpected death, whether there was an issue around clinical competency, possibly. That would be very different to coming and saying: we think that this nurse may be deliberately causing some harm.

Q. Yes. They are clearly different but if the nurse -- if the professional came to you and said "we have concerns because the deaths are unexpected and unexplained and they are always on duty", so that is specific, so they are not saying we have seen anything, but they are concerned because the deaths are unexpected and unexplained and the same nurse is always on duty, what was the correct, would you say, safeguarding response to that?

A. I think I would -- I mean, obviously I would be escalating that to Karen. But I would want to understand more in relation to whether there was a clinical competency issue and issues like that as

well.

Q. So you would refer it to someone more senior --

A. No --

Q. -- first of all?

A. -- I would --

Q. To Karen?

A. No, I would discuss it with Karen but then we would have a discussion, and a pretty quick one about, you know, what else had been considered, was this -- was this nurse -- were there any concerns about her competency, irrespective I think of, of what might have been occurred, I think one of the first things we would have thought about was: well, should that nurse be working there from this day while we think about whether the clinical competency is an issue?

Q. If we can go to paragraph 26 of your statement, you deal with this to an extent and you say:

"In the event of suspicions or concerns being raised with me about a member of staff being involved in deliberately causing harm ..."

So this is sort of one ramp up from a scenario I have put to you, but if the concern was deliberately causing harm to a child as opposed to suspicion that there is a correlation, you say you would have escalated

that immediately and would have:

"... expected the Executive lead for safeguarding would be notified, consideration of the need for an onward referral to the Local Authority Designated Officer and police would take place as a matter of urgency."

You use the word there "consideration" of the need.

Are there any circumstances if there was a concern about deliberately causing harm to a child where it wouldn't go to the LADO?

A. No, not.

Q. You don't there, but I think you have made it clear in your answer, refer to any immediate action in terms of removing the individual from --

A. That would be -- I would expect there to be a strategy discussion initiated with a matter of urgency. We would need to -- the first thing to do would be to establish immediate safety in relation to any other children, so that would form -- that would be the initial thing. How can we make the situation safe now and what do we need to be doing in terms of referrals to LADO and possibly the police if -- if there is suspicion of criminality?

Q. So, Ms Sindall, your response is admirably clear about what you felt were the stages to take but we

know that when Dr Jayaram raised a concern, in fact a specific concern that he was concerned about harm being caused to one of the Triplets after their sibling had died, that none of those steps were taken; that the nurse wasn't removed from the situation, there wasn't an immediate referral up.

Have you got any insight from your position as the safeguarding team who were doing the training of the staff of why -- why that occurred, why the nurses, senior nurses, Karen Rees, Eirian Powell, Alison Kelly it appears didn't view that as a safeguarding concern?

A. I don't know and I'm very surprised.

Q. In terms of the police, at what point would you have been considering the police in that scenario, so we have got a precise scenario in fact because we have got a Consultant who's concerned about a nurse, who's been present at a number of unexpected and unexplained deaths and then is talking about a specific concern related to a specific baby on the ward at that time?

A. That -- immediate I would have thought. It would need to go to the -- if you are talking about deliberate harm to a child and that's been witnessed.

Q. Well, I don't think anyone is suggesting witnesses --

A. When you talk about Dr Jayaram --

Q. Dr Jayaram was expressing his concerns --

A. His concern.

Q. So no suggestion of anybody witnessing, but simply a concern --

A. Right. Okay.

Q. -- that these -- a child or children in that case were considered at risk?

A. I think that that would form part of a discussion with the LADO and the LADO should have been informed really immediately and part of the -- because they are available on the phone as well, the LADOs, and I have spoken to them on the phone, so you would be able to pick up the phone, speak to the LADO and say: we are going to make a formal referral but this is the concern. And I'm fairly sure, knowing the LADOs that I have had contact, with that they would have been discussing the need to inform the police.

Q. If we can just look at something slightly different now, the Safeguarding Strategy Board. So if we could go to INQ0102620, so this was the -- it's going to come up in a moment, the Terms of Reference for this board, Ms Sindall.

This was a board that you sat on as the Safeguarding Strategy Board?

A. Yes.

Q. These are the Terms of Reference, so it just sets out what that board was intended to do. It met every two months, we will look at the attendees in a moment but you attended as did Karen Milne, Dr Isaac, Dr Mittal, Alison Kelly, Sian Williams, Julie Fogarty and the Deputy Director of Human Resources, Dee Appleton-Cairns. Just before we look at these terms of reference, why was there the Director of Human Resources, Dee Appleton-Cairns, what was the relevance of her being on a safeguarding -- it may seem obvious to you but why would you have someone from human resources on a Safeguarding Board?

A. Because there has been recommendations before around staff recruitment, Disclosure and Barring Service and also because HR would be involved if there were any sort of allegations against staff. So it's important that HR policies have a link up in some way with safeguarding.

Q. If we can just look at that, it's come up now. So the sixth bullet point down. At the very top it says the purpose, it reports to the Quality & Safety Patient Experience Committee, responsible for ensuring safeguarding is the strategic objective within the Trust. Then it talks about the duties.

The sixth bullet point is:
"To ensure that the Trust is reporting effectively to external agencies when we have safeguarding concerns."
So to that extent, in terms of the duties and what it was trying to achieve, the Safeguarding Strategy Board in this case, it failed, didn't it?
A. Yes.
Q. If we can just then turn to the INQ0043309, so this is just an example of an agenda for the Safeguarding Strategy Board on 15 April. We can see there that at point 9, LADO cases -- sorry it's just come up -- would be considered?
A. Yes.
Q. Lessons learned. I think compliance is generally discussed.
We see at 10, the fourth bullet point down, learning from significant incidents, local/national. So learning from other incidents was something that would be on the agenda and if we could then go over to page 3. So what this pack of documents appears to be is there is an agenda and then attached to the agenda in the normal way are the minutes of the last meeting --
A. Yes.
Q. -- and then some other documents?

A. I don't.
Q. But had you had a pack with documents you would presumably have normally have read it?
A. I would try to before the meeting.
Q. Looking there, though key points, what's your view about those points, do you agree with that, bearing in mind this is talking about what were the key learning points from this Trust in relation to a situation where concern was raised about a member of staff harming patients, in fact harming children?
A. Well, it has --
Q. Yes, do you agree with it, do you feel these are useful points?
A. Yes.
Q. Just going through them, we see there escalation at early action as per safeguarding policy; early disbelief must be an explanation, communications with patients and families, and they note: superb support from the police at the beginning of the year-long experience.
That is what I think we have established you would expect to happen where there was a concern about a staff member?
A. Yes.
Q. So the question is it would appear that this

A. Yes.
Q. If we just look at the minutes there of the meeting, we see -- actually if we can go on to page 4.
We see there compliance, for example, is one of the things that would be discussed and it says there Group 1 and 3., so Group 3 is what we are interested in for the neonatal unit, neonatal are above 80%.
Then in terms of the other documents that were attached to this, do you remember when you received agendas and minutes receiving other documents?
A. Yes.
Q. Attached?
A. There would be a big bundle of attachments.
Q. In this document, one of those attachments and if we could turn, be calling up while I am setting this out, page 102, one of the attachments here was a set of PowerPoints that came from another Trust in which there had been a concern about a member of staff harming patients and in fact who was later convicted of sexual abuse in that case that was the harm being caused to the patients in there and this PowerPoint set out key points.
Now, I think your evidence is that you don't actually recall seeing this at the time, this PowerPoint?

learning was being shared and we saw from the agenda that one of the items was learning lessons from other areas, learning from significant incidents.
This was in April 2016, so before for example Child O and Child P had died, had been murdered. Do you think there was a failure to incorporate that learning into the training?
A. That PowerPoint to my knowledge, I had never seen it until it came through in my bundle, so I don't recall there being any discussion of it at the Strategy Board meeting at all.
Q. Setting aside that, so you don't recall it, but do you think in fact that is the sort of thing that should have been within the training, thinking now?
A. The whole PowerPoint or the --
Q. Not necessarily the whole PowerPoint but those messages that don't appear in the PowerPoint at the Countess of Chester?
A. Yes, some of those messages could have been incorporated into the training.
Q. Is there any one you want to pick out in particular or broadly, is that the message, I am not saying that PowerPoint, but those --
A. I think escalation and early action as per safeguarding policy, so it's clear that somebody

understood the safeguarding policy at that hospital Trust.

Q. Just returning to when you first recall being made aware that there were concerns about harm being done to babies, just take it in stages. When did you first become aware that there were increased mortality and concerns about that?

A. I had -- I was aware that there was a review that had been ordered by the Royal College of Child Health and Paediatricians in relation to increased mortality.

Q. Was that the first time because of that review that you learnt about increased mortality or --

A. Yes, and I don't know how I learnt about that review. But -- but that was the first time I was aware that there was increased mortality on the neonatal unit.

Q. And did you at that point think were you aware that those were sudden and unexpected -- unexpected and unexplained deaths or --

A. No.

Q. -- did you not have that level of knowledge?

Had you known that those were unexpected deaths, what would your view have been about the SUDiC procedure, would you have considered that should have taken place?

A. We didn't really in our side of the team, Karen and myself, have an awful lot to do with SUDiC, we very much saw it as a responsibility of Dr Mittal.

Q. Was that the case also for the Child Death Overview Panel?

A. Yes.

Q. Did you understand SUDiC was the process would take place if there had been an unexpected death in hospital?

A. No, I didn't.

Q. You didn't think SUDiC was -- took place where death had been in hospital or you didn't know, sorry?

A. I didn't -- I knew it took place. I mean, the experience that I had had around SUDiC in relation to attendances at the hospital were those deaths that occurred outside of the hospital and came into the hospital.

Q. If someone had come to you and said "there's been an unexpected, unexplained death" what would you have done? Would you have referred that to Dr Mittal is that your evidence?

A. I would have thought that the paediatricians would be involved anyway.

Q. So you -- is it right to say you didn't have involvement with SUDiC?

A. No.

Q. But the understanding you had insofar as you had an understanding was that it wasn't put in place where the death occurred in hospital?

A. I -- I --

Q. You just didn't know?

A. I just didn't know.

Q. In terms of when you recall first being made aware that there were concerns that a nurse was possibly harming babies, when did you become aware of that?

A. When Karen Milne returned to the office after she had a one-to-one with Alison Kelly, which was a routine -- her supervision was with Alison Kelly and I noticed a real change in her demeanour when she came into the office. She seemed really quite upset and I said: how did your one-to-one go?

And she told me that Alison had discussed with her not that she was seeking advice but had discussed with her that they were going to call the -- either had already or were about to call the police in relation to concerns that somebody was -- that a member of staff was involved in harm to the babies on the neonatal unit.

Q. It is that detail that helps us to date it because that would suggest that this is March/April 2017 if it was just after or just prior --

A. I don't know, I don't know when it was.

Q. But as far as you were concerned, it was either just after or just before the police were involved?

A. It was either at the time or a day or two before.

Q. So just looking at that, by this stage, by March/April 2017, we have had the RCPCH review and Letby in fact was moved off the ward back in July 2016. There's been the RCPCH review, there's also been a grievance procedure. Were you aware of the grievance procedure?

A. Not until I received the bundle.

Q. There's been significant numbers of meetings between the paediatricians and the Executives and there is clearly a huge issue and a huge safeguarding failure that has occurred to get to the stage where the police are being called at this event in 2017 and I am just wondering if you can assist on the apparent disconnect between you delivering safeguarding training once a month, attending a Safeguarding Board and yet the safeguarding team, certainly in terms of you and Karen Milne, were unaware, completely unaware that there were concerns about a nurse harming babies?

A. I do wonder whether the status of the

safeguarding team within the hospital wasn't as -- as high as it should be, that would have made it a more natural thing, maybe for the paediatricians to think. So, for example, head of safeguarding or something like that, there were just the two of us getting on with the day-to-day work and I don't think that our status within the hospital or our importance within the hospital was as it should have been.

Q. You are clear, are you, that despite getting on the neonatal unit, you say you worked proximity, you didn't hear anything about nurses talking about a nurse being moved off the unit or --

A. Nothing whatsoever.

Q. Can we just go to the last document then, INQ0004715. This is the annual report, the Safeguarding Children's Annual Report for 2016/2017 what involvement, if any, did you have in drafting that?

A. This was a document that was put together by Karen Milne that she relied on other people providing information contained within it. So, for example, for CDOP she would go to Dr Mittal and say: do you need to put any -- you know, do you have any information around CDOP?

I would put in -- she would ask me for information about the LSCB quarterly audits that I attended and any

learning from them that could go in the report or any new initiatives around early intervention, I would.

So it was a document that was pulled together by Karen but it contained information from lots of different people.

Q. If you can just go to page 19, so just to set this in context as well. So this was dated July 2017, it's -- so by July 2017 the police are involved. It was clear that multiple individuals had not reported their concerns about Letby to the LADO, in fact, they still hadn't taken place, that -- certainly for a prolonged period it hadn't been referred to the police and in essence there had been a safeguarding failure. It hadn't been picked up as a safeguarding issue.

We look then at the little paragraph there under "Countess of Chester neonatal unit investigation", it says:

"There were a cluster of neonatal deaths identified between June 2015 and June 2016 at the Countess of Chester which are being investigated by the Cheshire Police. As a result of this Inquiry some changes have been made to the Pan-Cheshire CDOP process called ..."

The SUDiC protocol and then it goes on.

But there is nothing in that report by way of serious reflection as to what's gone wrong with

safeguarding and was that really adequate in what was the annual report of safeguarding, given what had occurred?

A. My understanding of that paragraph from discussion with Karen Milne is that she was given.

Q. Sorry, discussion at the time?

A. No, not at the time. Subsequently. Or I can't remember exactly when, not relatively recently but some discussion when that was put in there, that Karen told me that she was given that paragraph verbatim by either Alison Kelly or the Mel Kynaston, the Associate Director of Nursing, to put this in verbatim.

MS BROWN: Well, we can ask Alison Kelly about that.

Thank you very much, Ms Sindall. I have no further questions and there aren't any questions from any Core Participants.

Questions by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Thank you, I have just got one question, if I may, Ms Sindall. Could we bring up on the screen INQ0043309. It was a single page of a PowerPoint presentation.

MS BROWN: I think it is page 102.

LADY JUSTICE THIRLWALL: Thank you, Ms Brown I omitted to make a note of that.

That's it. Now, that was something that was provided at the time but you didn't see it?

A. No.

LADY JUSTICE THIRLWALL: And have no memory of looking at it?

A. That wasn't discussed at the strategy board.

LADY JUSTICE THIRLWALL: No.

A. I don't recollect it being discussed.

LADY JUSTICE THIRLWALL: You don't remember it, no all right.

So just the short question from me is they have got the starting point and then the second bullet:

"Early disbelief -- must be an explanation."

A. (Nods)

LADY JUSTICE THIRLWALL: Which -- I mean, you tell me what you think. It seemed to me that what that's saying is at the beginning people just don't believe the allegation and that there must be some other explanation.

A. Yes.

LADY JUSTICE THIRLWALL: Is that something which in your experience can affect the way people approach concerns?

A. I think so, yes. I do. And it's very hard to think that somebody in a position of care and that's

trusted to provide that care and to -- to provide safe care would deliberately want to harm, yes, I think that it's -- it's a natural thing for people to say "surely not".

LADY JUSTICE THIRLWALL: I suppose that's why training is important, isn't it, to remind people as you put it, thinking the unthinkable.

A. And I think that's why it was in the policy, we need to think the unthinkable.

LADY JUSTICE THIRLWALL: Yes. Thank you. Have you got anything else, Ms Brown?

MS BROWN: There is nothing else.

I think I have covered it in my questions but Ms Sindall, was there any other reflection you wanted to add? I omitted to ask the question.

A. Just I wasn't aware that -- when I got that PowerPoint through, I wasn't aware that it had been sort of sent as part of a bundle, so my question was around the PowerPoint: how, I guess when we are aware when, there is a multi-agency working and a child dies there is a serious case review, there is a clear process to, you know, discuss whether or not it becomes, does that child becomes the subject of a serious case review, there's certain learning that takes place that is then readily available via the NSPCC host, a repository of

all the serious case reviews, so that people who are wanting to learn and maybe to pass on that learning can access that learning that way.

When it happens in the NHS, and it may be my naivety around serious cases, but when there's only -- a tragedy like this where children come to harm, there is only one agency involved, I don't know whether these children become subject to a serious case review and if they don't, then the investigative process and the learning from that isn't available or is it available? Is there some national initiative or some national mechanism around patient safety where incidents like this when they occur, that learning that occurs as a result of it is then available for, across the NHS?

I -- it might be my naivety, maybe it is.

The learning from Thirlwall will be available publicly for people to reflect on and include in their training but, you know, this one from Cambridge, yes, they took it upon themselves to send out a PowerPoint or was there, I would wish to understand the mechanism by which learning around serious incidents like this, serious safeguarding incidents, whether there is an established mechanism for sharing that across the NHS.

LADY JUSTICE THIRLWALL: Yes, thank you. We know

that this certainly was shared.

A. Yes.

LADY JUSTICE THIRLWALL: We know how far it got, certainly as far as you were concerned.

A. Yes.

LADY JUSTICE THIRLWALL: Yes, but thank you for that and we have got your other reflections already. So those are my questions.

No one else has any questions, so you are free to go and we will break and we will start again at 20 to 4.

(3.22 pm)

(A short break)

(3.40 pm)

LADY JUSTICE THIRLWALL: Yes.

MR DE LA POER: My Lady, our final witness for today is Dr Isaac. I wonder if she might come forward.

DR HOWYADA ISAAC (affirmed)

LADY JUSTICE THIRLWALL: Do sit down, doctor.

A. Thank you.

LADY JUSTICE THIRLWALL: Yes, Mr De La Poer.

Questions by MR DE LA POER

MR DE LA POER: Please could you give us your full name?

A. Dr Howyada Isaac.

Q. Can you confirm please that you gave a witness

statement to this Inquiry dated 25 June of this year?

A. I confirm.

Q. Is the content of that true to the best of your knowledge and belief?

A. Yes. There is a slight error with the date I was appointed as a Consultant, in the second paragraph, I think.

Q. I am sure we will be able to correct that but other than that, is the content true to the best of your knowledge and belief?

A. Yes, it is.

Q. Let's deal with your background.

Did you qualify as a doctor in 1986?

A. Yes.

Q. Have you worked in paediatrics since 1990?

A. Yes.

Q. Did you become a member of the Royal College of Paediatrics and Child Health in 1998?

A. Yes.

Q. I think you first became a Consultant in 2005; is that right?

A. Yes, that's correct.

LADY JUSTICE THIRLWALL: 2005.

MR DE LA POER: That's correcting the error in your witness statement, I hope?

A. Yes.
Q. Did you join the Countess of Chester in 2012?
A. That's correct.
Q. Did you join both as a Consultant and as the named doctor for safeguarding?
A. Yes.
Q. Now, in terms of what that role meant, was it your responsibility to ensure that the organisation you were working for, the Countess of Chester, met its safeguarding responsibilities?
A. That's right.
Q. Did that include the Countess of Chester's responsibility to protect children from harm?
A. That's correct.
Q. Now, being the named doctor for safeguarding is, would you agree, an important role?
A. Yes.
Q. It is a role which is identified in statutory guidance, isn't it?
A. That's right, yes.
Q. Just tell us very briefly, please, between the difference between the role of named doctor for safeguarding and that of the designated doctor?
A. So the named doctor for safeguarding, I work for the Trust and I ensure the standards of safeguarding

within the Trust are met. The designated doctor works for the CCG and looks into safeguarding within the primary care and outside of the Trust.
Q. We know --
A. And also other agencies including -- works very closely with social care, which we do as well.
Q. Now, we see from your witness statement, we don't need to go through it, but you undertook a very substantial amount of training for the role of named doctor; is that right?
A. Yes, correct.
Q. During the period 2015, 16 and 17, approximately how much time per week or per month were you spending on the role of named doctor?
A. So I am given two programmed activities per week which is equivalent to one day per week.
Q. Did you find that that was sufficient for your safeguarding role?
A. Yes, it was.
Q. In terms of the safeguarding structure at the Countess of Chester, Alison Kelly was, as we understand it, the Executive lead for safeguarding?
A. That's right.
Q. Just help us to understand, that isn't a role named in statutory guidance unlike yours. Who had

overall responsibility for safeguarding at the Countess of Chester?
A. So I would have responsibility for the clinical, for the strategic, but Alison Kelly would be the head of safeguarding as my line manager with regards to the safeguarding part of my role.
Q. In practice if there was a disagreement between the two of you about how to respond in the safeguarding setting, who has the final say on what should be done?
A. So Alison Kelly would be the Exec team, so she would be above me. But if I -- if we disagreed, there is a method of escalation so I could escalate.
Q. And so does it follow then that if she said no, we are not going to do that and you disagreed with her, you could nevertheless take another route to ensure that your view was carried forward?
A. I could escalate but it would be hard.
Q. And who would you escalate it to?
A. So I could talk to Dr Mittal the designated doctor or I can and -- and through him escalate to the LADO.
Q. Now, in terms of your line management by Alison Kelly, did you have one-to-one meetings with her as part of your safeguarding role?

A. No, I didn't.
Q. We have heard that other roles did have one-to-one meetings with their line manager. Why didn't you have one-to-ones with Alison Kelly?
A. I only met her in the Safeguarding Strategy Board meetings but we never had one-to-one --
Q. But was that something you ever asked for?
A. No, I haven't.
Q. Why not?
A. I tend to have safeguarding supervision through Dr Mittal, designated doctor for safeguarding and it's more around the medical aspects of the service and it's not something that she has offered me either.
I don't think there was a close relationship between us in that sense.
Q. Can I just ask a direct question then. I mean, there wasn't a close relationship between us. Is that a euphemism for the fact that the two of you did not get on professionally?
A. No, no, we just didn't meet -- we only met in the Safeguarding Strategy Board meeting.
Q. If Alison Kelly became aware of a safeguarding issue, did you have an expectation that she would tell you?
A. It's not something that had happened whilst

I was there.
Q. I understand that but you are the named doctor?
A. Yes.
Q. You are the person who is charged with in the statutory guidance to ensure that the Countess meets its safeguarding responsibility. Doesn't that mean that you should know about every safeguarding issue within the hospital?
A. I expect to know, yes, especially things that would be within my role.
Q. I am not suggesting anything that Alison Kelly came across, but if it is a safeguarding issue or potentially a safeguarding issue --
A. Yes.
Q. -- although she may be senior to you in management terms, the responsibility sits with you, doesn't it?
A. Yes.
Q. And therefore you should be told everything, shouldn't you?
A. Yes, I couldn't possibly manage everything on my own because that's why we have safeguarding nurses and they deal with other issues as well. But yes, definitely we should have been discussed serious things,

yes.
Q. We are going to have a look at three policies in a moment just briefly, but before we get to that, as part of your safeguarding training and no doubt your wider medical training, were you aware of previous situations where a member of staff had harmed patients deliberately?
A. Within the Trust?
Q. No, not within the Trust within the NHS. I am here thinking about Harold Shipman, Beverley Allitt, Colin Norris, Victorino Chua?
A. Yes.
Q. Were you aware of all four of those cases?
A. I was aware of Harold Shipman and Beverley Allitt.
Q. Does it follow from that that you weren't aware that a nurse at a hospital not too far from the Countess of Chester was sentenced in May of 2015 for murdering two patients with insulin and poisoning others; did you know about that?
A. I have -- I have -- I have heard about it in Stockport, yes.
Q. Yes.
A. I have heard about it but not in detail.
Q. So was that not a case that was circulated on

the safeguarding circuit as an opportunity to remind safeguarders that they needed to be looking inward towards members of staff as well as outward?
A. No, this is -- wasn't included in any safeguarding training. It was my knowledge through these cases was through the media.
Q. We are going to look now at Working Together. INQ0014575 and we are just going to look at four pages, we will start at page 2 and just run through with you, if we may, Dr Isaac, how we get to page 54, so 52 first.
So we can see this is under the chapter "Organisational responsibilities" and this is really just so that we can track through how we get to an important part of this document. It begins by saying at paragraph 3 that section 11 places a duty on, among other things, NHS organisations; do you see that?
A. Yes.
Q. If we go over the page, we will see that paragraph 4 says: these organisations should have in place arrangements that reflect importance of safeguarding and promoting welfare of children. Then it gives a list of effectively what, among others, NHS organisations should have.
Now, one of those, we can pause briefly on, is the third bullet point from the bottom which is a designated

professional lead for safeguarding. And here that's referring to a role such as you had, the named doctor role; is that right?
A. Yes, for health providers it is named doctors, yes, named professionals.
Q. Yes, and we see that in the brackets.
There is one other matter that appears under that heading at 4 of what organisations should have, it is just over the page, we have looked at it many times but I would like to look at it with you:
"NHS organisations should have clear policies in line with those from the local Safeguarding Children's Board for dealing with allegations against people who work with children."
There is then a list of three bullet points of the way in which an allegation against an individual might be framed.
The language, as we have observed many times, is "may" or "possibly" or "may pose a risk". Did that accord with your understanding at the time in 2015/16/17 of the way in which safeguarding allegations should be thought about?
A. Yes.
Q. Now, just reflecting back on it. Did the Countess of Chester have a clear policies in line with

the local safeguarding children's board in terms of how such allegations should be dealt with?

A. Yes, it was written in the safeguarding policy and welfare of children.

Q. So we are going to get that that in just a moment; that is where the clear policy is to be found, is it?

A. Yes.

Q. Before we get to that, one final element of this just to bookmark, page 57. We can see the third and final bullet point on this page, that:

"A named doctor should be identified as well as a named nurse."

Then four lines up from the bottom -- five lines up from the bottom:

"Named professionals have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals and ensuring safeguarding training is in place."

So did it form part of your role to give advice from a safeguarding perspective to your colleagues within the hospital?

A. Yes, it was.

Q. That's a role that you have by virtue of being a named doctor?

A. That's correct.

Q. Thank you, we can take down Working Together.

The next policy we are going to look at is the Cheshire West and Chester Council Interagency Policy, INQ0007918.

Now, is this a document that you are familiar with?

A. No, is this part of the LSCB, is it on the --

Q. This is Cheshire West and Chester Council.

A. Right, okay.

Q. It is the Threshold for Initiating Safeguarding Procedures?

A. Yes.

Q. It is an interagency document?

A. Yes.

Q. If we look at the large paragraph in the centre:

"Determining whether or not abuse of a person has taken place is not always a straightforward matter, particularly when concerns relate to neglect. A judgment will be required about whether an act or omission has caused significant harm. The multi-agency arrangements for responding to concerns exist to establish whether or not abuse has occurred. It is very important that these arrangements [and it talks about the discussion and the meeting at a strategy level] are

triggered if there is a possibility that abuse has occurred."

So again summarising that: was it your understanding that whether or not abuse had occurred is a matter for the multi-agency response. What's important is that if there is a concern it is brought forward to the multi-agency level?

A. Yes.

Q. So the final policy to look at is the Countess policy, INQ0014165. If we look at page 3, I am sure you can tell us as that comes up that there seemed to be a number of fairly similar version of this document from around this time that we have invited you to consider ahead of time.

Do you know why the policy appears to have been amended and updated a number of times?

A. I don't know but usually it's every couple of years, so I'm not sure why there are so many versions of it.

Q. Can you confirm that there are a number of versions with, for example, this September 2015 date as we see in the centre of page 3?

A. Yes.

Q. So if we go to page 11, is this series of bullet points the process that you were talking about

that is contained within this policy?

A. Talking about with regards to?

Q. Working Together says there needs to be a very clear policy --

A. Yes.

Q. -- at the local level about what it do if abuse is suspected, if an allegation is made?

A. Yes.

Q. Is this the process, is my question?

A. Yes, there's a flowchart as well about how to escalate and what to do.

Q. Is that the flowchart that we have heard spoken about as being put up on the walls?

A. Yes.

Q. When we look at what's contained within the policy, this part of it appears to focus upon a starting position of when a child is suspected to have been abused is admitted to the hospital; do you see that?

A. Yes.

Q. So it seems to start from an assumption that the suspected abuse is from outside?

A. Yes.

Q. I mean, do you think that the Countess' policy dealt adequately with the thinking that perhaps it could be a member of staff who was responsible for harm?

A. There is a section -- another section as well about the whistleblowing policy.
Q. Yes.
A. If you suspect there is a member of staff who are concerned. But over here, I think we are looking at the common scenarios, this is a very uncommon scenario, this is very rare and when we are looking at this policy it was looking into most of the cases that we do get are children who come in with bruises or injuries and as paediatricians or nurses or medical staff or clinical staff we have to deal -- and we suspect abuse and it's never been, never -- you never for certain in child protection, there is no certainty and it's all on the balance or probability and suspicion. And this is the commonest scenario that we do get.
Q. I was just going to ask about that because the phrase "balance of probability" you use in your witness statement. Balance of probability ordinarily means more likely than not, or greater than 50% chance, whereas "suspicion generally" or "possibility" or "may" allows for a lesser degree of certainty?
A. (Nods)
Q. Which did you think was the correct level of test that needed to be applied before you had a safeguarding concern that you had to respond to?

A. We get safeguarding concerns and we assess the probability and we will -- with regards to escalation, we don't have to be certain to escalate but we have to have a degree of suspicion.
Q. Yes, but do you need to have so much suspicion that you are right at the start saying it's more likely than not that this is the explanation or can you have a lesser degree of suspicion?
A. We can have a lesser degree of suspicion. And when in this particular case when you get somebody coming from outside, you will see all cases and decide yes or no on balance of probability less likely, there are different balances, or more likely or probable.
So it, it's -- we would assess and then when we produce our report we will say on the balance of probability we think this is likely or unlikely, yes.
Q. When you get to the back end of the process as to making a finding as to whether or not there has been abuse or neglect, then you are applying that standard, is that what you are saying?
A. Yes.
Q. But at the start of the process in order to --
A. Yes.
Q. -- raise it with safeguarding and for safeguarding to say this requires an investigation,

potentially take it to the LADO, that doesn't require balance of probabilities at that stage, does it?
A. No, you have concerns, yes.
Q. Now, we have heard already about the Safeguarding Strategy Board which as we understand it is a board that reported to QSPEC; is that right?
A. Reported to?
Q. To the QSPEC meeting, the Quality Safety Patient Experience Committee?
A. (Nods) I didn't attend that committee.
Q. Well, let's have a look at the document behind it, INQ0102620. Now, when you say "I didn't" -- as that is coming up, you didn't attend QSPEC but did you attend the Safeguarding Strategy Board?
A. Yes.
Q. So if, as we bring that up, we have looked at this already, we don't need to go over what we have already looked at, it starts at page 16 within this document. There's just one part of it that I wanted to ask you about, which is at page 19.
We can see there under "frequency of meetings", there is a provision within this policy for an emergency meeting, do you see that?
A. Yes.
Q. Now, presumably an emergency meeting might be

called if there was a very serious safeguarding concern which was emerging at the hospital?
A. Yes.
Q. So does it follow that although this is a strategy board for safeguarding concerns of the most serious type, as in a particular case this board could also discuss that?
A. It can, but I would expect to have discussed it on a one-to-one before bringing it to such a large group.
Q. Now, we will come back in a moment to a particular Safeguarding Strategy Meeting, I just want it ask you briefly about training. Again the Inquiry has heard a lot about training. There's one document I want to take you to, INQ0108344.
Now, this has got your name attached to it. Do you see that towards the top?
A. (Nods)
Q. To whom were you providing this training?
A. As far as I remember, I was doing it jointly with Paula Lewis to hospital staff. I don't think it was specifically for medical staff, I think it was generic training.
Q. There is only one slide -- and we have already looked at it once today -- I would like you to look at,

page 74. This appears to be, if you like, the sign-off slide, the closing message, the "if you take away one thing from this talk, it is this", is that fair?

A. Yes.

Q. That is how you are signing off to everybody?

A. Yes.

Q. That it's everybody's business, if you have suspicions pick up the phone?

A. Yes.

Q. Presumably when you are telling all the people you are training: pick up the phone, you are telling them: pick up the phone to me or my colleagues in the safeguarding department?

A. Yes.

Q. Is that right?

A. Yes.

Q. When you provided training, was that the sort of message that you were giving at the end of every presentation that you made?

A. Yes, it's -- to raise awareness of safeguarding is everybody's business.

Q. Thank you. We can take that down. We are just going to look at somebody else's slideshow here. INQ0043309 and I think you heard questions after your colleague earlier this afternoon, so you will know the

document we are going to have a look at, it is at page 102.

It formed part of a pack for a Safeguarding Strategy Meeting in February of 2016 and it would appear that your colleagues in Cambridgeshire had provided this slideshow which they were circulating about an experience that they had had.

Do you have a recollection of having seen this slide which forms part of about a 10-slide presentation?

A. No, I can't remember.

Q. It's provided to the Safeguarding Strategy Meeting as part of the material for that meeting. I mean, was there an expectation that you would read all of the enclosures for a meeting?

A. Yes.

Q. So if it forms part of the enclosures, would you expect that you did read this at the time?

A. Yes, I would try my best, yes.

Q. In terms of good practice, we can see "escalation and early action in accordance with the safeguarding policy and immediate suspension"; presumably you would regard that as a very important albeit neutral step in a safeguarding investigation?

A. (Nods)

Q. That the moment there is concern about an

individual in this case a member of staff, they need to be suspended?

A. Yes.

Q. Is that the sort of advice that you would have been prepared to give back in 2016/7 if someone had brought such a concern to you?

A. Yes.

Q. We can see early disbelief must be an explanation.

Did you have any experience of allegations being made against a member of staff and the reaction of people around as to whether it may or may not be true?

A. Yes, I think that is a very natural reaction; that people don't think of somebody caring for children would harm children and especially when you think what's the motive. So yes, of course people will resist and will think there must be some other explanation.

Q. So that is the staff and colleagues.

Is it important for the safeguarders to think a little more clearly about it though?

A. Yes, and we have been taught to think the unthinkable because the same thing happens when you get a parent coming with a child and a person doesn't want to think that the parent could be harming the child because that's not natural, but we were taught you have

to think the unthinkable.

Q. Thank you and we can obviously see in this case that there was police support from the very beginning. In the case of an allegation of a crime, would you expect the police to be involved at the very start?

A. I would.

Q. Thank you. We can take that down now.

So we are going to turn now to events at the Countess. The first thing is just to understand your geographical situation. We have heard from Dr Holt that you and she shared an office; is that right?

A. Yes, Dr Holt was a new Consultant so she came in later, maybe when I was reading through the document, it was towards the end of the process.

Q. So it was March 2016, I think that she --

A. Yes.

Q. -- joined?

A. Yes.

Q. Dr Holt replaced Dr Newby. Did you share an office with Dr Newby before Dr Holt started or did you just have your own office?

A. No, I didn't share an office with Dr Newby.

Q. Did you share it with any of the consultant paediatricians before Dr Holt?

A. Yes, I did.
Q. Who did you share it with? Do you want to just check the cipher list to make sure if ...
A. Yes, it is V something. ZA.
Q. Dr ZA.
A. Yes.
Q. So that position, did that apply up until March of 2016 when Dr Holt arrived?
A. Yes.
Q. So in the period that you were sharing an office with Dr ZA, did you become aware of the increase in mortality on the neonatal unit?
A. I can't remember the exact date when I came aware of the increased mortality, but it was late and I definitely wasn't aware of the concerns of my colleagues until I met with Steve Brearey and his appraisal and that was the time when I was really aware of what was going on but before that I -- I wasn't really -- I may possibly have known about the mortality because there was the Royal College review, so I probably knew at that point. But I can't pinpoint a specific date --
Q. But my question was directed to the period before March 2016 just thinking about the time that you were sharing an office with Dr ZA and whether you ever

spoke to her about it or whether she ever mentioned in passing to you that there had been an increased number of deaths; do you have any recollection of that at all?
A. No, I wasn't aware.
Q. Once Dr Holt joined, but before June of 2016, do you have any recollection of hearing about it from Dr Holt?
A. No, I don't.
Q. Looking back on it, does it surprise you that that wasn't bearing in mind that you are sharing an office with people who are experiencing that every day in terms of the thoughts about it, the discussions that they have told us they were having that nobody mentioned it to you?
A. I -- we all -- we were all in a corridor, we had offices in a corridor and there was lots of doctors in that corridor, we all shared offices there. I think there were five offices and I possibly heard a baby died, heard something like that, but not heard the full story, not -- wasn't aware about the full extent of their concerns and their suspicions.
You know, they discuss cases all the time, they discuss, you know, issues, they will stand in the corridor and talk but I wasn't aware of -- of the degree of their concerns. It -- I don't think they at that

point during that time -- I don't know how much they were aware either because, you know, it was an evolving picture.
Q. The Inquiry heard a great deal of evidence from them. From your point of view. In the event that your Consultant colleagues were discussing a particular member of staff, and discussing between themselves whether or not the association that member of staff had may be sinister, is that the point that they should have been talking to you?
A. Yes, but I have not heard them discuss about a member of staff on the corridor.
Q. Were you aware of the downgrading of the neonatal unit in July of 2016?
A. I don't know when I became aware of the downgrading of the neonatal unit.
Q. Well --
A. I can't remember.
Q. Were you aware that the Trust in the first early days of July 2016; were operating what it described as a Silver Command?
A. Yes, I -- I have not heard that term but I knew that they were.
Q. Looking at the list of invitees, it doesn't appear that any member of safeguarding was invited to

any of those what were very large meetings, we have heard 36 people in one room. Should safeguarding have been invited to that -- to those meetings?
A. Which meetings?
Q. The Silver Command meetings. There was a period of three days as consideration was given to downgrading the neonatal unit and setting in train a series of investigations and reports?
A. I wasn't aware of those meetings.
Q. Should you have been aware?
A. If there are safeguarding concerns they should have let us aware, yes.
Q. We know, for example, at the end of June just before that process started, that Dr Jayaram had conducted research about whether air embolism, the deliberate administration of that could be responsible for some of the deaths, so in other words he was investigating a possible murder method.
Should you have been made aware that that was a piece of research that he was conducting?
A. The first time I have heard of that was during the trial. I don't know when he was conducting that research, what period do you refer to?
Q. You can take it from me that it was 30 June of 2016.

A. Right, okay.
Q. Should you have been told about that?
A. Yes.
Q. Now, you were interviewed by the Royal College on 1 September?
A. (Nods)
Q. In the morning, Dr Jayaram and Dr Brearey, with support of the other five paediatric Consultants, had told the reviewers about their concerns that Letby may be deliberately harming babies.
In your meeting with the Royal College that afternoon, were you told about those concerns?
A. No.
Q. Should you have been told?
A. Yes.
Q. In fact, if we just have a look at one perhaps striking example, INQ0014604, page 25. These are notes taken by the Royal College as part of their review.
Do you see where it says the word "TOM"? In fact we have established that should say "team", that's just a mistranscription.
This is the lunch time meeting of the reviewers. They spent part of the lunch discussing ways in which deaths may have been caused deliberately. You can see there "INS", "INS". We are not going to go into the

detail of that. It should in fact say "insulin injection" or "air embolism". So they were discussing that at lunchtime.
Can you that the very next thing that they record doing under that line is that they came to speak to you?
A. They came to speak to me?
Q. If we look, we can see that after they'd had that lunchtime discussion they met with you and with other safeguarding colleagues?
A. Yes, yes, a joint meeting.
Q. Yes, in the joint meeting.
A. Yes.
Q. Should they have told you about their discussion that they'd had at lunchtime bearing in mind your safeguarding role?
A. Yes, yes, but that was not mentioned at all in our meeting. It was all general safeguarding policies and procedures in the Trust.
Q. Thank you. We can take that down.
So we are just going to spend a moment or two looking at your appraisal with Dr Brearey. You have told us that that took place on 22 November 2016 and you weren't meeting him as a safeguarder, but as a professional colleague conducting his appraisal?
A. (Nods)

Q. What did he tell you in that appraisal about the concerns that he had?
A. So -- I went back for the purpose of this to read -- I remember that he told me about the increase in mortality rate going up to 13 babies from being 1 to 3 and that this nurse was on duty every time a baby died and they've had concerns. And he's done some reflection notes there as well, which I have read through, and -- and how he has escalated it to the managers but they haven't responded to him and at the time he was -- and he was concerned as well because of -- there was a grievance coming up and that he would be asked to sit in a mediation for several hours for this mediation process and grievance.
Q. Now, in terms of what he told you about the increase in mortality, the fact that there was an association with a member of staff, and that he was concerned about that I mean he was telling you, wasn't he, that he was worried that that member of staff may have murdered babies --
A. Yes.
Q. -- is that fair?
And that is a clear safeguarding concern, is it not?
A. So at the time that wasn't regarded as

safeguarding and I suspect that's why my colleagues haven't approached me as a safeguarding lead.
The typical safeguarding scenario, like you pointed out, is a child coming through the door with bruises or injuries and you deal with that as a clear safeguarding case. But a member of staff causing harm to babies and murdering babies was thought to be like more of a crime that would require police investigation.
Q. You --
A. My colleagues are all very experienced in safeguarding and none of them had come to the safeguarding team and I -- I suspect, obviously I am not talking on their behalf, but I suspect it's because it wasn't as clear-cut as what we think now.
Q. But you have --
A. Another -- another thing I would like to point as well is at the time when I knew about it, this had already been escalated to the highest level. The senior management, the top, you know, in the hospital were aware of it and Lucy Letby had already been removed from the neonatal unit.
So when we talk about safeguarding, we talk about children who are still alive and we are safeguarding them. But in this case, she had been already removed, the children were safe in the unit and we were dealing

with child death and that's a different process to the safeguarding.

Q. But by the end of November of 2016, plans were afoot to return Letby to the ward. Doesn't that just demonstrate why you should have intervened at that stage?

A. Yes. If she were to be returned to the ward, I definitely would have escalated it.

Q. But you didn't know unless you went and found out what was going on and what the plan was?

A. But I was -- you know, I -- I had talks with Dr Brearey at the time and -- and I was waiting to see what would come out of the reports because you say you don't have to be sure to raise the alarm bells, which is correct, if you have suspicions, that's correct. But when you are making a referral you want to give a good quality referral.

And a lot of people were saying at the time and would say, "This is just a coincidence, you can't blame a member of staff because of rise of mortality. You need to look into medical causes first. You need to look into competencies. There could be other possibilities."

But now, with the benefit of hindsight, we know that she was guilty but at the time we didn't.

Q. But --

A. And -- and it's that sort of information I was waiting for so that to escalate I would have that to back me up.

Q. Well, did you ask Dr Brearey what his Consultant colleagues thought in paediatrics on the ward?

A. What they thought about ...?

Q. Yes, whether they agreed with him, whether they were worried?

A. Dr Brearey told me that they, he -- they were worried, that Dr Jayaram and himself were regarded as troublemakers because of escalating this or raising concerns.

He was the head of the department, so he was talking on behalf of everybody else.

So he -- I don't know if the rest were worried or not, but I know that, you know, I -- that he was, he was sincere in what he was saying and I'm not saying that in any way he was, he was wrong.

No, on the contrary, he stood up for the children.

What he did was right. And they had already escalated it and they had already gone up to the chief Exec and the Medical Director and they had -- weren't listening to them.

Q. But bearing in mind what you have told us about the fact that any serious safeguarding concern, even if it's communicated to Alison Kelly, should be given to you, were you not concerned that there had been a failure here to notify you about this?

A. Yes. As a safeguarding lead, like I say Dr Brearey, when he spoke to me, he wasn't referring to me for safeguarding -- to -- for a safeguarding process to be followed.

He was telling me this as part of his appraisal.

Q. If somebody tells you a safeguarding concern in any context, you have a responsibility to act upon it, don't you?

A. Yes, definitely. Yes.

Q. And looking back on it, do you think that in fact at that moment, in November, you should have immediately contacted Alison Kelly and said, "I'm the named doctor. I need to know what's going on here"?

A. Yes, and -- and that's why I sort of wrote a letter to Alison Kelly and to express concerns about safeguarding the children.

However, I didn't send that letter. I was waiting for more evidence from the reviews. I knew that the babies were safe and that Lucy Letby was working in a clinical -- in a non-clinical area.

Q. Well, by January, it had been resolved at board level to seek to return her to the ward. You hadn't asked any questions, so you couldn't have known that.

Didn't you need to find out about what the plan was?

A. Yes, but I -- I knew that this is a possibility and I would have escalated it if that were to happen. In retrospect now, with the benefit of hindsight, I, you know, I do wish I had sent that letter sooner and I wish I had escalated it as soon as Dr Brearey told me about this issue.

Q. Well, in fact you typed the letter on 7 February of 2017, so that was, well, over two months later. I mean, do you think that that was an acceptable period of time to leave it before you started writing that letter?

A. No. In hindsight, I should have escalated it earlier.

Q. Well, let's have a look at what was in your mind on 7 February, INQ0102620, and we will need to go to page 22.

So it begins with you making clear the capacity that you are writing in and that was entirely appropriate for you to do so, wasn't it? You were

perfectly entitled to write to an Executive Director in those terms because this is your responsibility, isn't it?

A. Yes.

Q. And you are enquiring about the outcome of the investigations. So at this stage all you are trying to do is find out what's happening?

A. Mmm mm.

Q. And you pose two questions, which include whether the reason has been identified at the second one and if there has been an increase in risk to babies on the neonatal unit and you conclude by saying:

"If these questions cannot be answered, then further investigations may be warranted to ensure that we are safeguarding children in our care and to ensure we can protect our babies from future risk."

A. Yes.

Q. Now, all you are doing is asking questions at this stage, aren't you?

A. Yes.

Q. Why didn't you send this letter?

A. I was debating whether to send it or not and then I knew the investigation has happened, there was an investigation, we are going to get a review, and if we get a review and these deaths are confirmed as

unexplained, unexpected -- they are not due to medical causes -- then we -- there is more evidence to escalate it higher and there will be a stronger basis for doing this.

And the review had already happened. We were just waiting for the report, so it's, you know -- and the babies were safe, as far as I knew, at that point in time. I would have known if they -- if Lucy Letby were to go back because I was in contact with Steve at that point.

So once, you know -- I didn't know that they were withholding the neonatal case review report. I wasn't aware of that until I read all the emails, but I expected that as soon as that review was done the report would be available and I didn't know that was going to be delayed and that it was being withheld.

Q. You say you would have known if Letby was returned to the ward. It would be too late once she was actually returned to the ward, wasn't it? You would need to know at the point that the decision was being made --

A. Yes.

Q. -- so that you could have an input in it?

A. Yes.

Q. Did you know that in fact it was decided to

return her to the ward and a date for that was set by the Executives? Did you know that?

A. No, I didn't. I knew there was talks about the possibility of her returning after the grievance process, but I didn't know there was a date set.

Q. Again, looking at the situation as you now understand it to be, doesn't that rather tend to suggest that you not intervening and trusting that Dr Brearey would report to you what was going on wasn't really an adequate response by you given what was at stake here which was the safety of children? Do you agree with that?

A. I agree.

Q. Now, the final thing I want to ask you about is the Local Children's Safeguarding Board and related to that the safeguarding report that was prepared by your colleague Karen Milne. So we will deal firstly with the Local Children's Safeguarding Board.

They should have been notified of what was going on at the Countess, shouldn't they?

A. But that would have been through Alison Kelly.

Q. But was it not your responsibility, as named doctor, to make sure that they knew?

A. Yes.

Q. And at any point in this time -- here we are

talking from November through to the time we know the police became involved at the end of April -- did it occur to you to think: I really must make sure that the Local Children's Safeguarding Board is aware?

A. So that is what I was trying to do by sending the letter to Alison Kelly because I would expect to discuss it with her first before escalating to the local Safeguarding Board or to LADO. That would be a discussion.

I wasn't -- I didn't know at that time. I think she knew about everything all along but at that time, I didn't know what she knew and therefore I felt that I should talk to her first before the escalation because that is the process, to go through your safeguarding lead and at least have a discussion there and if she doesn't agree then that's something else you would escalate by a different means.

Q. We know you didn't send the letter. Did you speak to Alison Kelly about this before 27 April of 2017?

A. No.

Q. Why not?

A. Well, I was sending the letter as a means of opening a discussion but that never happened.

Q. Well, why didn't you send the letter?

A. Because I was waiting for the neonatal report, I was waiting ...

There was also a culture of fear as well. So it's a very sensitive issue. The Consultants were threatened to lose their jobs, they were told that a red line is drawn under this and they didn't want any more discussions about this and they all didn't know what to do. So there was sort of -- I had to take it sensitively and I wanted more evidence to support me.

Q. I mean, you are the person as the named doctor to ensure that this organisation meets its safeguarding responsibilities. Wasn't it your responsibility to become involved as soon as you could and to stay involved to make sure that that obligation was discharged?

A. Yes, I agree, I should have escalated it earlier.

Q. The second part is the safeguarding report, INQ0004715. Now, this is for 2016-17.

Now, it's authored by Karen Milne, but presumably it is a document that you will have read and potentially contributed to as it was being drafted?

A. Yes.

Q. And we will just look at page 7 first, paragraph 6.3. Described in it, not by any particular

reference to any particular event, is the description of the LADO, the local area designated officer -- the Local Authority Designated Officer.

We can see at the second sentence:

"The LADO must be contacted within one working day in respect of all cases in which it is alleged that a person who works with children has behaved ..."

I mean, that's a perfectly conventional understanding from a safeguarding perspective, isn't it?

A. Mm-hm.

Q. And you knew in this case that the LADO had not been contacted within 24 hours of the allegations being raised, didn't you?

A. Yes, but it wasn't as clear-cut as this because it -- they were told that it's a coincidence, it's increased mortality and you can't blame somebody because of statistics. And so it, it wasn't clear allegations, it wasn't -- initially they were looking for medical causes as well. So it wasn't as clear-cut as where there is a clear allegation or a clear incident and that's why they didn't raise it as safeguarding.

Q. Dr Isaac, you have told us that you as a safeguarder had special training to understand that as we saw at Addenbrooke there will be "initial disbelief -- must be an explanation."

You knew that your role was to see past that and to focus single-mindedly upon the safety of the children.

Do you think that you did that?

A. No, I should have escalated it earlier, I agree with that.

Q. Page 19, please. I think we are looking at paragraph 11.5. We can see under the heading "Neonatal Unit Investigation" that there is a short summary given of events. What is not there is anything about the concerns of the Consultants or the fact that a safeguarding issue had been raised.

Should that have been included otherwise, isn't this misleading?

A. Yes. I didn't contribute to this. I don't know who, who did, whether -- I have heard my previous colleague Paula Lewis who said that to Alison Kelly, or it could have been somebody else, or whether it's Dr Mittal. I don't know who's put that paragraph there.

Q. But presumably you read it though at the time?

A. Yes.

Q. And presumably you knew from what you had been told by this stage that it was misleading in the sense it didn't include that additional detail?

A. Yes.

Q. Knowing that it was misleading, did you say

anything?

A. No, and I can't remember when I read this either.

MR DE LA POER: Thank you very much indeed for answering my questions, Dr Isaac. There is one permission, but I don't know whether or not all matters have been ... I am told there is one short matter.

LADY JUSTICE THIRLWALL: Would you like to come forward.

Questions by MS WOODS

MS WOODS: Thank you, Dr Isaac. My name is Leanne Woods, I am asking some questions on behalf of a group of Families.

I have just got one matter I wanted to deal with you, please.

I have read your witness statement, others have read your witness statement and I want to ask you about some of the reasons for your inaction after you learnt of Dr Brearey's suspicions and I think also the inaction of others that you have given in your witness statement.

So as I read your statement, you are saying, amongst other things: this was unchartered territory, you and others were not clear about what to do. Do you agree with that?

A. Yes.

Q. You also said that the various hospital boards and committees were not suitable for examining these kinds of issues, including because of the sensitivity of the matter, is that right?

A. Yes.

Q. Would you also agree that if there is a suspicion that a healthcare professional may have committed what was an incredibly serious criminal offence against babies that Executives are not equipped to investigate this kind of thing?

A. (Nods)

Q. Just for the record, if you could answer rather than simply nodding.

A. So I would say, like we discussed previously, the escalation process would be the Freedom to Speak and discussion with referral to LADO; that would have been the right route to follow.

Q. Okay. And part of the reason is that if people are thinking that there may be these incredibly serious criminal offences being committed, Executives/healthcare professionals just don't have the skills or the equipment to investigate that kind of thing, do they?

A. No.

Q. Given those factors, do you agree that this

is -- what was encountered with Letby was exactly the kind of circumstances where safeguarding professionals like you and Executives should be looking outside of the Trust?

A. Yes, yes.

Q. And you should be looking to the local multi-agency safeguarding arrangements that already existed and that specialise in responding to and investigating safeguarding concerns?

A. The local -- sorry?

Q. The local multi-agency safeguarding arrangements. So things like, well, we've talked about the LADO already?

A. Yes, yes.

Q. The local safeguarding children's board?

A. Yes.

Q. CDOP, if relevant, and of course also the police, do you agree?

A. Yes, yes.

Q. And of course that is what would have happened if healthcare professionals or indeed Executives in the hospital had had concerns that a child was suffering harm or was at risk of harm at home in the community?

A. Yes.

Q. Because healthcare professionals in the Trust

in those circumstances wouldn't seek to keep the concerns in-house, would they? They would go out to the established multi-agency arrangements?

A. Yes.

Q. And that's what should have happened here?

A. Yes. Yes.

MS WOODS: Thank you, my Lady. Thank you, Dr Isaac.

LADY JUSTICE THIRLWALL: Ms Woods, thank you very much.

A. Thank you.

LADY JUSTICE THIRLWALL: I have no questions for you. Thank you very much indeed for coming, Dr Isaac.

A. Thank you.

LADY JUSTICE THIRLWALL: Thank you. So we will rise now until 10 o'clock tomorrow morning.

Thank you all.

(4.43 pm)

(The Inquiry adjourned until 10.00 am, on Tuesday, 19 November 2024)

I N D E X